|  |   | 1 - State<br>Registrar   |  |   |  |  | Ce   | rtificate of  | f Death  | 1           |  | Reg. No.   | 005  | 1,200  |
|--|---|--|--|---|--|--|--|---|--|-------------|--|--|--|--|
| Physicia   | an  | 1. Decedent's Name   |  | dle, Last)  |  |  | 5,   | mers  |  |             | 2. Date of Dea<br>Month  | Day  | Year   |  |
| /Medic   | al  | David  |  |   |  |  | 3UW  |   |  | . ( 5 - 1)  | Decemb   |  |  |  |
| Examin   | er  | 4a. Facility Name (If  |  | _   |  |  | 14.1   | 4b. City, Town,   |  | pr          | ١.   | 4c. County of Death None   |  |  |
|  |   | The Joh  |  | 6. Sex  |  | T Age (In v  | rs. last birthday)   |   | r If Under   |             | ,  |  |  | irtholace (State or Fo   |
| Funeral<br>Director  |   | 522-02-4   | 155  |   | M 2□F  |  | 45 Yrs.  | Months Day  |  | Min.        | 8. Date of Birt<br>Month Da<br>NOV • 25  | , 1 <b>9</b> 60  | ) d  | irthplace (State or Fo<br>Country)<br>OLOTAdo  |
| Mo to  |   |  | 10b. Coun  | ty  |  | 10c.   | City, Town or Lo   | ocation   |  |             |  |  |  | 10d. Inside City Li  |
| if Health and Mental Hygiene.<br>Item 27 is marked other than "natural", or items 23a or 28a-f show<br>other traumatic event, I've Medical Ever it er must be notified at                    | ţō  | Md.  | Мо   | ntgo  | mery   |  | Silve  | r Spring  | 3  |             |  |  |  | t½∏Yes 2[  |
| r 28a  | rec   | 10e. Street and Num  |  |   |  |  |  | 10f. Zip Code   |  |             |  | 10g. Citize  | en of What (   | Country?   |
| 23a c  | a D   | 125 East   | West   | Hig   | hway   | #1514  |  |   | 20910  | •           |  |  | USA  |  |
| ams<br>Er Ell  | Funeral Director                                    | 11. Marital Status   |  |   | 12. Was Dec  | edent Ever in  | n U.S. 13.   | Was Decedent of   | Hispanic O   | rigin? (Spe | ecify Yes or No  | - 14   | 4. Race - An<br>Black, Wh  | nerican Indian,  |
| or the   | Fu  | 1 ₹ Never Marrie   |  | arried  | 1 ☐ Yes<br>If Yes, Gi  | 2X No  |  | 1 ☐ Yes 2X N  |  |             | 1110411, 010.7   | 1  |  |  |
| le la  | d b   | 3 Widowed 4  | 4 Divorce  | ed  | Year or D  | ates:  |  |   |  |             |  |  |  | White  |
| "natu  | Completed by  | (Specif  | 15. Decede<br>fy only high   | ent's Educ  | cation<br>completed)   |  | 16a. Dece<br>(Give   | dent's Usual Occ<br>kind of work don<br>DO NOT use reti   | upation<br>e during mo   | st of worki | ing  | 16b. Kind of Business/Industry   |  |  |
| han<br>han   | dm  | Elementary/Secon   | ndary (0-12  | )   | College (  | 1-4or 5+)  |  | Lc Relat:   |  |             |  | D11 h  | olic D   | elations   |
| Mental Hygiene.<br>arked other thar<br>atic event, ILEN  | ပိ  | 17. Father's Name (F   | Eint Middle  | o ( act)  |  | :  | Publi  | c Relat.  |  |             | (First, Middle,  |  |  | eracions   |
| d of   | Be  | Donald F   |  |   |  |  |  |   |  |             | Neill  | Maldell S  | ourname)   |  |
| i Mer<br>narke   | 은   |  |  |   | B.C.A  |  | 405 44 77  |   |  |             |  | 0.1  | T C1-1-  | To Contain   |
| Is my  |   | 19a. Informant's Nar   |  |   |  | - L - 20   | 1  | ng Address (Stree   |  |             |  | -  |  |  |
| Healt<br>m 2<br>her t  |   | Kenneth  |  | ımmer   | S/ brot  |  |  | 7 Aviation (Name of   | OII LOU  | 2 4         | Date   | _  |  | or Town, State   |
| = 5  |   | 1 ABurial 2  |  | n 3 □R  | emoval from  | State  | cemetery, cre  | matory or other p   |  |             |  |  | •  |  |
| tange of the second  |   | ° 4 □ Donation   |  |   |  | M  |  | et Cemet  | - ,  |             | 13,05  |  | ningto   | n, bc  |
| Depart<br>Import<br>any in   |   | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 2   |  |   |  |  |  |   |  |             |  |  | nc 20057   |  |
|  |   | 1  | 2010   | 11  | 1950   | Ins  | 1  | ZZZ WISC  | onsin  | PAG.        | , 14W . , Wet  | Burne  | 500113   | DC 20001   |
|  |   | 23a Part Enter the<br>shick, or heart  | e disease,   | or compli   | cations that o   |  |  |   |  |             |  |  |  |  |
| ysician  |   |  | t failure. Li  | ist only or   | ne cause on e  | caused the d<br>each line.   | leath. Do not en   | ter the mode of d   | ying, such as  | s cardiac c | or respiratory ar  | rrest,   |  | Approximate<br>Interval Betwee   |
|  |   | mediate Cause (F   | Final  | ist only or   |  |  |  |   |  |             |  |  | ,  | Onset and Dea  |
| Medical  |   | mediate Cause (F   | Final  | ist only on   | Due to   | gressi<br>(or as a con   | sequence of):  | tifocal L   | -euko  | sence       | phalop   |  | ,  | Onset and Dea  |
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| Medical<br>caminer   | iner  | mediate Cause (F<br>disease or condition<br>resulting in death)  | Final<br>1   | ist only on   | Due to   | gress<br>(orasacon<br>man  | sequence of):  |   | -euko  | sence       | phalop   |  | 7  | Onset and Dea  |
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|                            |  |                  | 1 - For State Registrar   | State of Maryla                                 |                             | artment of H<br>rtificate of L               |   |                                    | ene 05                              | +2002  |
|----------------------------|--|------------------|---|---|-----------------------------|--|---|------------------------------------|-------------------------------------|--|
|                            | Discoveries :  |                  | 1. Decedent's Name (First, Middle, Last,                                      | )   |                             |  |   | 2. Date of Death<br>Month          | Day Year                            | 3. Time of Death                                 |
|                            | Physici<br>/Medic  |                  | Agnes P. Smitl  | າ   |                             |  |   |                                    | 9 2005                              | 10:19 PM   |
|                            | Examin   |                  | 4a. Facility Name (If not institution, give<br>Genesis Health(                |   | D:                          | 4b. City, Town, or                           |   |                                    | 4c. County of Dea                   | th   |
|                            |  |                  |   |   |                             |  | aston If Under 24 Hrs.                    | O Bata of Birth                    | Talb                                |  |
|                            | Funeral Director   |                  | 5. Social Security Number 6. Sec. 1217–169913                                 | IM 2NE  | rrs. last birthday)<br>Yrs. | Months Days                                  | Hours Min.                                | 8. Date of Birth<br>(Month, Day, ) | 9. Bir                              | thplace (State or Foreign                        |
|                            |  |                  | Usual Residence of Decedent   | 84  |                             |  |   | Sept.16                            | ,1921 Ma                            | ryland   |
|                            | how  |                  | 10a. State 10b. County  | 10c.  | City, Town or Lo            | ocation                                      |   |                                    |                                     | 10d. Inside City Limits                          |
|                            | e Ma   | ctol             | Maryland Talbot   | E   | aston                       |  |   |                                    |                                     | 1 X Yes 2 □ No                                   |
|                            | or 28  | Dire             | 10e. Street and Number  |   |                             | 10f. Zip Code                                |   | 100                                | g. Citizen of What Co               | ountry?  |
|                            | ath w  | Funeral Director | 400 E. Dover Stree  |   |                             | 21601  |   |                                    | USA                                 |  |
|                            | Hemeller de  | nne              | 11. Marital Status 1 ☐ Never Married 2 ☐ Married                              | 12. Was Decedent Ever in Armed Forces?          |                             | Was Decedent of His<br>If Yes, specify Cubar | spanic Origin? (Spo<br>n, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)   | 14. Race - Ame<br>Black, Whit       |  |
| 36                         | urs aff  | by F             | 3 X Widowed 4 □ Divorced  | 1 ∐Yes 2 ∰ No<br>If Yes, Give<br>Year or Dates: |                             | 1 ☐ Yes 2 No                                 | Specify:                                  |                                    | Specify:                            | Black  |
| ŏ                          | 72 hours after death with the Maryland<br>naturel; or iteme 23a or 28e-f ehow<br>issal Examination until be notified a   | Completed by     | 15. Decedent's Edu  | cation  | 16a. Dece                   | dent's Usual Occupa                          | ition                                     | 16                                 | 6b. Kind of Business                |  |
| 218                        | within 7<br>ene.<br>than "n  | ple              | (Specify only highest grad  | e completed) College (1-4or 5+)                 | (Give                       | kind of work done d<br>DO NOT use retired;   | uring most at work                        | ng                                 |                                     |  |
| 7                          | filed wil<br>Hygien<br>ther th<br>ent, the   | Con              | 12  |   | N <sub>1</sub>              | ırse   |   |                                    | Nursing                             |  |
| nd                         | lid be fill<br>fental H<br>rked oth  | Be               | 17. Father's Name (First, Middle, Last)                                       |   |                             |  |   | (First, Middle, Ma                 | ,                                   |  |
| Maryland 21215-0036        | should Ind Mening Market   | ٩                | John H. Plummer   |   |                             |  |   |                                    | oldsborou                           |  |
| Mai                        | d 2 st<br>th and<br>7 is n<br>treun  |                  | 19a. Informant's Name/Relationship (Ty  |   |                             | -  |   |                                    | City or Town, State,                | Zip Code)  |
| e,                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel; or Iteme 23a or 28e-f ehow any injury or other treumatic event, the Medical Extending must be notified a anone. | i P              | Hilbert Turner, Co  |   | b. Place of Dispo           | sition (Name of                              | 1   | -                                  | and 21662<br>Oc. Location - City or | Town, State                                      |
| 101                        | Pages<br>nent of<br>ont: If Its<br>ury or o  |                  | 1 Ø Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)              |   | •                           | matory or other place                        |   | V.                                 | ,                                   |  |
| Baltimore,                 | permit. P<br>Departme<br>Importen<br>any injur   |                  | 21. Signate: of Fundal Service Licens   |   |                             |  |   |                                    | Easton, Ma                          | ryland   |
| B                          | Depa<br>Impo<br>any ir   |                  | an Vi Sort  | <del>2)</del>                                   |                             | 2. Name and Addres<br>Bennie Sr<br>426 Dover | nith Fune<br>Screen.E                     | ral Home<br>ascon.Mai              | ryland 21                           | 601  |
|                            |  |                  | 23a. Part1. Elter/the disease or complishock, or near failure. List only or   | ications that caused the d                      | eath. Do not en             | er the mode of dying                         | , such as cardiac                         | or respiratory arres               | it,                                 | Approximate<br>Interval Between                  |
|                            | Physician  |                  | Immediate Cause (Final disease or condition                                   | Prairet   | [3001]                      | n sel  | statio                                    |                                    |                                     | Onset and Death                                  |
|                            | /Medical   |                  | resulting in death)   | Due to (or as a con                             | sequence of):               | 1) //LEN                                     | 110011                                    |                                    |                                     | years  |
| н                          | Examiner   |                  | Sanuartially list over things   | ,   |                             |  |   |                                    |                                     |  |
|                            | D #  | Examiner         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a con-                            | sequence of):               |  |   |                                    |                                     |  |
|                            | and<br>-trans  | каш              | that initiated events resulting in death) Last                                | Due to (or as a con:                            | enguanea of):               |  |   |                                    |                                     |  |
| 38760,                     | ficate be executed<br>physician and<br>s the burial-transit  | a E              |   | 040 10 (01 43 4 001)                            | 334431103 01).              |  |   |                                    |                                     |  |
| 587                        | ficate<br>phys<br>s the  | edicai           |   | j   |                             | -  |   |                                    |                                     |  |
| Вох                        | law requires that the death certific<br>as been signed by the attending F<br>2 should be detached for use as   | N/M              | IF FEMALE:<br>23b. Was decedent pregnant                                      | 3c. If yes, outcome of pre                      |                             |  |   |                                    | 23d. Date of de                     | livery   |
| ň                          | death<br>e atte<br>d for   | Physician/M      | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 1□Live birth 2□F<br>4□Pregnant at time          |                             | Ectopic pregnancy Other (specify)            |   |                                    | Month                               | Day Year   |
| P.O.                       | tt the<br>by the<br>tache  | hys              | 9 Unknown   | 9□ Unknown                                      |                             |  |   |                                    |                                     |  |
|                            | es tha   | by F             | Part II. Other significant conditions con                                     | 1   | _                           | 4.   | n in Part I.                              | 23e. Did toba                      | \/                                  | the cause of death?                              |
| ord                        | w require<br>been sig<br>should b  |                  | MATERIAL DEGITE   | celva puli                                      | nonenj                      | disease                                      |   | 1 🗆 Yes                            | 2 □ No 3 ØP1                        | obably 4 Unknown                                 |
| ecc                        | has be   | Completed        | Asheroscheroge  | ,   |                             |  |   | 24a. Was an autopsy                | prior to                            | stopsy findings available completion of cause of |
| <u>=</u>                   | Phyeiclen: The I<br>this certificate ha<br>al director, page   | Con              | Drabetes mell   | he  |                             |  |   | performe<br>1 ☐ Yes 2 🖟            | ed? death?<br>ANo 1 ☐ Yes           | 2 No   |
| Vita                       | iclen<br>certifi<br>ector  | Be               | 25. Was case referred to medical examiner?                                    | loopital.                                       | 2-510-                      | [D#10  |   | (Check only one)                   |                                     |  |
| of                         | Phye<br>this<br>al dir   | P.               | 1 ☐ Yes 2 No  |   | ER/Outpatier                |  | 4 Nursing Ho                              |                                    | ce 6 ☐ Other (Spe                   | cify)  |
| uo                         | ding<br>h.<br>After<br>funer   | tlon             | 1 Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year         | 28b. Time o<br>Injury       | Work   | at<br>?<br>'es 2 □ No                     | 28d. Describe how                  | injury occurred                     |  |
| Division of Vital Records, | Atten<br>deat<br>ctor:<br>y the  | fica             | 3 Suicide 6 Could not be  | 28e. Place of Injury - A                        | it home, farm, sti          |  |   | 28f. Location (Stree               | et and Number or Ru                 | ural Route Number.                               |
| ā                          | al or after after I Dire   | Certification;   | 4 Homicide  | building, etc. (Sp.                             | ecify)                      |  |   | City or Town,                      | State)                              |  |
|                            | To the Hospital or Attending Physicien: The within 24 hours alter death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page  |                  | 29a. Certifier Certifying Physics   | sician: To the best of my                       | knowledge, deat             | h occurred at the time                       | e, date and place,                        | and due to the cau                 | se(s) and manner as                 | stated.  |
|                            | he H<br>in 24<br>he Fu   | edical           | (Check only 2 Medical Exami   | ner: On the basis of exam<br>and manner stated. | ination and/or in           | vestigation, in my op                        | inion, death occurr                       | ed at the time, date               | e and place, and due                | to the cause(s)                                  |
|                            | To t<br>Com  | Σ                | 29b. Signature and title of certifier   | nV n  |                             | 29c. License                                 | number                                    | 290                                | d. Date signed (Mont                | h, Day, Year)                                    |
| 1                          | _ \  |                  | · 114   | many  |                             | 1  | 1595/                                     |                                    | 16.1                                | 6.07   |
| (                          | (چ   |                  | 30. Name and address of person who co   | empleted cause of death (                       | Item 23a) (Type,            |  | hale F                                    | ASTON                              | MA O                                | 1601   |
|                            | Sta  | to.              | 31. Date filed (Mogth, Day, Year)   | 32. Registrar's Si                              | gnature -                   | MANS W                                       | INE E                                     | 11510M                             | 1111 2                              | 1001   |
|                            | Registr  |                  | 31. Date filed (Month, Pay, Year) DEC 15 2005                                 |   | 2 100                       | R  |   |                                    |                                     |  |

|             |  |                   | 1 - For<br>State<br>Registrar  | State of Man  |                                       | artment<br>rtificate         |                             |                            | ind Me                   | ,                                      | giene      | 005                           | 42003  |
|-------------|--|-------------------|--|---|---------------------------------------|------------------------------|-----------------------------|----------------------------|--------------------------|--|------------|-------------------------------|--|
|             | Physici  | an                | 1. Decedent's Name (First, Middle, Las   |   |                                       |                              |                             |                            |                          | 2. Date of Dea                         | ath<br>Day | Year                          | 3. Time of Death                             |
|             | /Medic   |                   | Raymond  | Kenne   | eth                                   | S                            | wab                         |                            |                          | December                               |            |                               | 3.4  |
| >           | Examir   | ier               | 4a. Facility Name (If not institution, give  | street and number)  |                                       |                              |                             | Location o                 | f Death                  |  | 4c.        | County of Dea                 | ath  |
|             |  |                   | 14410 Quail Lane   |   |                                       |                              |                             | rslie                      | 2111 - 1                 |  |            | Alleg                         |  |
|             | Funeral  |                   | 5. Social Security Number 6. Se  | ⊒M 2□E  | n yrs. last birthday)<br>SYrs.        | If Under 1<br>Months         | Days                        | If Under 2<br>Hours        | Min.                     | 8. Date of Birt<br>(Month, Da          |            |                               | rthplace (State or Foreign<br>Country)       |
|             | Director   |                   | 209-20-6567 Usual Residence of Decedent  | X 75  | ) 113.                                |                              |                             |                            |                          | 02/27/19                               | 930        | Pen                           | nsylvania                                    |
|             | land ow  |                   | 10a. State 10b. County   | 16  | Dc. City, Town or Lo                  | ocation                      |                             |                            |                          |  |            |                               | 10d. Inside City Limits                      |
|             | Mary<br>1 sh   | į                 | MD Alleg   | onv   |                                       | E11                          | -1:-                        |                            |                          |  |            |                               | 1 □ Yes 2 ☑ No                               |
|             | 28a  | rec               | 10e. Street and Number   | ally  |                                       | Eller<br>10f. Zip            |                             |                            |                          |  | 10a. Cit   | izen of What C                | Country?                                     |
|             | 3a or  |                   | 14410 Quail Lan  | o ( D O Boys '  | 773)                                  | 2                            | 1529                        |                            |                          |  |            |                               | •  |
|             | 72 hours after death with the Maryland<br>natural', or items 23a or 28a-f show<br>Jigal Exacitier must be notified at  | Funeral Director  | 11. Marital Status   | 12. Was Decedent Eve  |                                       |                              |                             | spanic Orio                | gin? (Spec               | cify Yes or No-                        | US.        | A.<br>14. Race - Am           | erican Indian,                               |
| ယ           | or ite   | 교                 | 1 ☐ Never Married 2 ☐ Married  | Armed Forces?<br>1 X Yes 2 No   | 1952-                                 |                              |                             |                            | , Puerto F               | Rican, etc.)                           |            | Black, Wh                     | ite, etc.                                    |
| 93          | al', o   | þ                 | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:  | 1953                                  | 1 ☐ Yes 2                    | ₩ No                        | Specify:                   |                          |  |            | Specify:                      | White  |
| 215-0036    | 72 ho  | Completed         | 15. Decedent's Ed  | ucation   | 16a. Dece                             | dent's Usual                 | Occupa                      | tion                       | a firm white             | _                                      | 16b. K     | ind of Busines                |  |
| 2           | within ene.  | ple               | (Specify only highest gra-<br>Elementary/Secondary (0-12)  | College (1-4or 5+)  | life.                                 | DO NOT use                   | e retired)                  | uning most                 | OI WORKIII               | g                                      |            |                               |  |
| 21          | filed wi<br>Hygien<br>sther th   | Con               | 12   | 2   | C                                     | omptrol                      | ler                         |                            |                          |  |            | Ballis                        | tics   |
| nd          | al Hy<br>al Hy<br>al Hy<br>al oth  | Be                | 17. Father's Name (First, Middle, Last)  |   |                                       |                              |                             | 18. Mothe                  | r's Name                 | (First, Middle,                        | Maiden     | Sumame)                       |  |
| Va          | should be find Mental Hind Men | 2                 | Raymond  | Lee   | Sw                                    | ab                           |                             | Jess                       | sie                      |  | Mae        |                               | Kipp   |
| Maryland    | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentat Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Modical Examiner must be notified at once.  |                   | 19a. Informant's Name/Relationship (7  | ype, Print)   | 19b. Maili                            | ng Address                   | (Street a                   | nd Numbe                   | r or Rural               | Route Numbe                            | or, City o | r Town, State,                | Zip Code)                                    |
|             | and<br>ealth<br>n 27<br>ser tr   |                   | Wilma G. Swab / wife   |   | 14410                                 | Quai1                        | Lane                        | (P.O.                      | Box 2                    | 73), E11                               | crsl       | ic, Mo                        | 21529  |
| Baltimore,  | of Hi<br>of Hi<br>if iter  |                   | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □  |   | 20b. Place of Dispo<br>cemetery, cre- | sition (Nam                  | e of                        |                            | Da                       | ate                                    | 20c. La    | cation - City o               | r Town, State                                |
| Ĕ           | Pag<br>nent<br>ant: i  |                   | 4 □Donation 5 □ Other (Specify   |   | MD Vet. Cer                           | m. @ Ro                      | ckv (                       | Sap 12                     | 2/20/2                   | 005                                    | FI         | intstone.                     | Maryland                                     |
| at          | permit. Departifimportiany inj   |                   | 21. Signature of Fureral Service Licen   | See / 4   |                                       | 2. Name and                  |                             |                            |                          |  |            |                               | ome, P.A.                                    |
| <u>m</u>    | 82553  |                   | Kalet C  | Helm  | 1                                     | 404 De                       | catur                       | Stree                      |                          |  |            | ryland :                      |  |
| i           | Physician  |                   | 23a. art1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition | olications that caused the  | e seath. Do not en                    | ter the mode                 | of dying                    | , such as o                |                          |  | rest,      |                               | Approximate Interval Between Onset and Death |
| ,           | /Medical<br>Examiner   |                   | resulting in death)  | Due to (or as a c   | onsequence of):                       | 112                          |                             |                            | r Cr                     |  |            |                               | 712.   |
|             | ted<br>nsit  | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Culsease of Injury                      | Due to (or as a c   | onsequence of):                       |                              |                             |                            |                          |  |            |                               |  |
| 8760,       | certificate be executed ding physician and ise as the burial-transit   |                   | that initiated events resulting in death) Last   | C. Due to (or as a c  | onsequence of):                       |                              |                             |                            |                          |  |            |                               |  |
| 687         | # × 6  | adle              |  | d   |                                       |                              |                             |                            |                          |  |            |                               |  |
| .O. Box     | death<br>e atter<br>ed for u   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of p<br>1 □ Live birth 2 □<br>4 □ Pregnant at tim<br>9 □ Unknown | Fetal death 3                         | ⊒Ectopic pre<br>□ Other (spe |                             |                            | -                        |  |            | 23d. Date of de<br>Month      | əliv <i>er</i> y<br>Day Year                 |
| Records, P. | law requires that the<br>as been signed by th<br>2 should be detache   |                   | Part II. Other significant conditions of   | entributing to death but n  |                                       | inderlying ca                | use give                    | n in Part I.               |                          |  |            |                               | to the cause of death?                       |
| 00          | s bee  | lete              |  |   |                                       |                              |                             |                            |                          | 24a. Was                               | an         | 24b. Were a                   | utopsy findings available                    |
| al Re       | The<br>ate h<br>page   | Completed by      |  |   |                                       |                              |                             |                            |                          | autop                                  | sy<br>med? | prior to<br>death?<br>1 ☐ Ye  | completion of cause of                       |
| Vital       |  | Be                | 25. Was case referred to medical examiner?   | Hospital:   |                                       |                              | Othe                        |                            |                          | (Check only o                          |            |                               |  |
| o to        | Phys<br>this<br>ral di   | ٠ <u>۲</u>        | 1 Yes 2 No   | 1 L Inpatient   | 2 ER/Outpatie                         |                              |                             | 4 LI NUI                   |                          | ie 5 <b>⊠ Re</b> sid<br>8d. Describe h |            | 5 □Other (Spe                 | ecify)                                       |
| Division    | Attending F r death. sctor: After by the funera  | catlon            | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injury<br>(Month, Day Yo   | ear) Injury                           | M                            | Sc. Injury<br>Work<br>1   Y | ?<br>'es 2 🗆 N             | No                       |  |            |                               |  |
| Divi        | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral  | Certification:    | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | building, etc. (  |                                       |                              |                             |                            |                          | City or Tow                            | m, State   | )                             | Rural Route Number,                          |
|             | the Host<br>in 24 hoi<br>the Fune<br>pletely fil   | ledical           | 29a. Certifier 1 ☐ Certifying Ph<br>(Check only one) 2 ☐ Medical Exem  | ysicien: To the best of n<br>iner: On the basis of ex<br>and manner stated            | amination and/or in                   | h occurred a                 | it the time<br>in my op     | e, date and<br>inion, deat | d place, ar<br>h occurre | nd due to the o<br>d at the time, o    | date and   | and manner a<br>place, and du | s stated.<br>e to the cause(s)               |
|             | To To To Com   | Σ                 | 29b. Signature and title of certifier  | 211   |                                       | 29c.                         | License                     | number                     |                          |  | 29d. Dat   | e signed (Mon                 | th, Day, Year)                               |
|             | 4/1UA  |                   | Im   | Klas  | me.                                   |                              | D0054                       | 4004                       |                          |  | Dec        | ember 19                      | , 2005                                       |
|             | l  |                   | 30. Name and address of person who o   | ompleted cause of deat  |                                       | -                            |                             |                            |                          |  |            |                               |  |
|             | MRS  |                   | Shiv C. Kha  | 15375   | 1221 Nation                           | -                            | way,                        | LaVal                      | e, Mai                   | ryland 2                               | 21502      |                               |  |
|             | Sta<br>Registi   |                   | 31. Date filed (Month, Day, Year)  DFC 1 9 2005  | 2. Registrar's  | Signature 103                         | de la                        |                             |                            |                          |  |            |                               |  |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Shirley Stafford Rae December 15, 2005 6:55 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 219 Wallace Street Cumber land Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🂢 F Director 70 Yrs 212-32-8053 10/02/1935 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f show other treumstic event, the Modical Examiner must be notified at Directo 1 Yes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? death with 219 Wallace Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No δ 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be titled within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other then \*? any higury or other treumatic event, If a Magnes. Elementary/Secondary (0-12) Coflege (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Wilbur Idella Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 219 Wallace Street, Cumberland, Maryland 21502 Debbie L. Strong / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 12/19/2005 Restlawn Mem. Gardens LaVale, Maryland 21. Signature of Jun ral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. ch 404 Decatur Street, Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence Division of Vital Records, P.O. Box 68760 signed by the attending physicien Physician/Medical fF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 90 þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2**X** No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 MResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3□ DQA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at Work? After 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D0062429 December 16, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TINS 47 Virginia Avenue, Cumberland, Maryland Ageel Saleem, M.D., . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Amended#8 perFH FCHD, KS 12 Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Grace Lyons Sunderland December 11, 2005 5:45P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg
If Under 1 Year | If Under 24 Hr Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2AF Days Months Hours Yrs. 99 Director 213<del>-</del>48-7913 Sept. Maryland 1906 August 1, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int! If Item 27 is marked other than "natural", or Items 23s or 28s-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir items 23a or 28a-f show remembel be notified at Yes 2□No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5458 Watercress Place 21045 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 23€ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1☐ Yes 2√2 No Specify: Item 27 is marked other than "natural", o other traumatic event, the Medical Exam Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Lyons ဂ္ Elsie (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lowell Sunderland - Son 5458 Watercress Place, Columbia, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State = 5 Department of important: If any injury or once. \* 4 Donation 5 Other (Specify) Mt. Olive Cemetery 12/14/05 Randallstown, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 21. Signalure of Funeral Service Lice Lovert of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician my ocaldeal by Snun disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner sician and burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed es, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 16 lindres 2 No 1 ☐ Yes Division of Vital the Hospital or Attending Physicien: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 🗌 Yes 2 No 2 Accident investigation after death Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Vithin 24 hours and To the Funerel Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IN Palent burse DOC4115 December 11, 2005

Registrar

DHMH 17 Rev 1/2001

State

122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2005

CUBALLY

etrar's Signature

14. ROBERTBIRS

201 RUSSELL

05-8304 B.K.S JEINA SPURLOCK

Amend

| / Unpend item# 1,23a,PII,27 penME,G85I,1/21/06 IT State of Maryland / Department of Health and Ment | al Hygiene 05 | 42007 |
|---|---------------|-------|
| Certificate of Death  | Reg. No.      |       |

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Funeral Director

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Deperment of Heelth and Mental Hyglene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show eny injury or other traumatic event, The Medical Examinating Individual and DOCE.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours effer death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

|                                  | T - State<br>Registrar                       |                       |   |  | $C\epsilon$                    | ertificat                    | te of L   | Death                      |                           |                                  | Reg.                 | No.                         |  |                            |               |
|----------------------------------|--|-----------------------|---|--|--------------------------------|------------------------------|---|----------------------------|---------------------------|----------------------------------|----------------------|-----------------------------|--|----------------------------|---------------|
|                                  | 1. Decedent's Name                           | e (First, Middle      | e, Last)  |  |                                |                              |   |                            |                           | 2. Date of D                     | eath                 |                             |  | 3. Time of                 | Death         |
| 1                                |  | 0                     | Sina Maria  | Spurlo                                   | ock                            |                              |   |                            |                           | Month                            | _                    | Day                         | Year   | 0017                       | , м           |
| L                                | 4a Fooility Name (                           |                       | n, give street and numb                                     | -  | JCK .                          | 4h City                      | DEC. 9, 2005  4b. City, Town, or Location of Death  4c. County of |                            |                           |                                  |                      |                             |  | 10947                      | _A            |
| ı                                |  |                       | PLACE   | <i>X</i> 61)                             |                                | C                            | OLUMI   | BIA                        |                           |                                  |                      | HOWA                        |  |                            |               |
|                                  | 5. Social Security N                         |                       | 6. Sex 7<br>1 ☐ M 2 ☐ XF                                    | . Age (In yrs.                           |                                | /) If Unde<br>Months         | r 1 Year<br>Days  | If Under<br>Hours          | 24 Hrs.<br>Min.           | 8. Date of B                     | lirth<br>Day, Yea    | ar)                         | 9. Births                                    | place (State on ntry)      | or Foreign    |
|                                  | 220 96 09                                    |                       | ILIM ZLAF   | 40                                       | Yrs.                           |                              |   |                            |                           | March                            |                      |                             |  | ine                        |               |
|                                  | Usuel Residence of                           | T                     |   | 10- 01                                   | - T                            |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
|                                  | 10a. State                                   | 10b. County           |   | 100.01                                   | ity, Town or I                 | Location                     |   |                            |                           |                                  |                      |                             |  | 10d. Inside Ci             |               |
| 3                                | MD   | Howai                 | rd  | Co                                       | lumbia                         | L                            |   |                            |                           |                                  |                      |                             |  | 1 Li res                   | 2 <b>2</b> No |
| 5                                | 10e. Street and Nu                           |                       |   |  |                                | 10f. Zi                      | p Code  |                            |                           |                                  | 10g.                 | Citizen of V                | /hat Cou                                     | ntry?                      |               |
| 5                                | 5455 Wil                                     | dwind I               | Place   |  |                                |                              | 2104  | 5                          |                           |                                  |                      | Unite                       | ed St  | tates                      |               |
| 5                                | 11. Marital Status                           |                       | 12. Was Deced<br>Armed Ford                                 |  | J.S. 13                        | . Was Dece                   | dent of Hi  | spanic Or                  | igin? (Spe                | ecity Yes or N<br>Rican, etc.)   | 10-                  |                             |  | can Indian,                |               |
| be completed by runeral Director | 1 Never Marr                                 | ied 2 Marr            | ned 1 Yes 2   | <b>⊠</b> No                              |                                |                              |   |                            |                           | riican, etc.)                    |                      | 1                           | k, White,                                    | etc.                       |               |
| Š                                | 3 🗆 Widowed                                  | 4 Divorced            | If Yes, Give<br>Year or Dat                                 |  |                                | 1 ☐ Yes                      | 21XI NO   | Specify:                   |                           |                                  |                      | Specify                     | B.   | lack                       |               |
| 2                                | (0,0   |                       | t's Education   |  | 16a. Dec                       | edent's Usu                  | al Occupa   | ation                      |                           |                                  | 16b                  | . Kind of Bu                | siness/In                                    | dustry                     |               |
| 2                                | Elementary/Seco                              |                       | st grade completed) College (1-4                            | lor 5+)                                  | life.                          | e kind of wo<br>DO NOT L     | ork done d<br>ise retired   | iuring mas<br>')           | it of worki               | ing                              |                      |                             |  |                            |               |
| 5                                | 7  | ridary (o iz)         | Oonoge (1   | .0.01,                                   |                                | Disab                        | led   |                            |                           |                                  | -                    | None                        | 9  |                            |               |
| פ                                | 17. Father's Name                            | (First, Middle,       | Last)   |  |                                |                              |   | 18. Moth                   | er's Name                 | First, Middl                     | e. Maio              | len Surnam                  | e)   |                            |               |
| 2                                | Stanley                                      | K. Spui               | rlock   |  |                                |                              |   | Lore                       | tta '                     | Washin                           | gtoi                 | n                           |  |                            |               |
| -11                              | 19a. Informant's N                           |                       |   |  | 19b. Mai                       | ling Addres                  | s (Street a   |                            |                           | al Route Num                     |                      | _                           | State. Zii                                   | o Code)                    |               |
|                                  |  |                       |   |  |                                |                              |   |                            |                           |                                  | 1 77                 | 1 3                         |  |                            | A A           |
|                                  | 20a. Method of Dis                           |                       | rlock/Fathe   |  | 5645<br>Place of Disp          |                              |   | arm                        |                           | Unit Date                        |                      | Location -                  |  |                            | 44            |
|                                  |  | •                     | 3 Removal from St   | ate                                      | cemetery, cri                  | ematory or                   | other plac  |                            |                           |                                  |                      |                             |  |                            |               |
|                                  | 4 Donation                                   |                       |   | P  | Metro                          |                              |   |                            |                           | 2-2005                           |                      | atons                       |  |                            |               |
|                                  | 21. Signature of Fu                          | neral Service         | Licensee ADD  | M010                                     | 044                            | 22. Name a                   | nd Addres   | s of Facili                | y Har                     | ry H.                            | Witz                 | zke's                       | Fami   | lly FH                     | Inc.          |
|                                  | > Slen                                       | n Jolli               | no Wyse   |  | 4                              | 112 0                        | la co   | olumb                      | ia P                      | ike El                           | lico                 | ott Ci                      | Lty,   | MD 210                     | 043           |
|                                  | 23a. Part 1. Enter t                         | he disease; or        | complications that cau                                      | used the dear                            | th. Do not e                   | nter the mo                  | de ol dying   | g, such as                 | cardiac                   | or respiratory                   | arrest,              |                             |  | Approximat<br>Interval Bet | 9             |
| 1                                | Immediate Cause                              | (Final                | 0.2011  |  | C D: 1                         |                              | 77.   |                            |                           |                                  |                      |                             |  | Onset and I                | Death         |
|                                  | disease or condition resulting in death)     | on                    | a. Complica   | TIONS C                                  |                                | etes Me                      | IIItus  | 5                          |                           |                                  |                      |                             | $\rightarrow$                                |                            |               |
|                                  |  |                       | 00 00 00  | as a consec                              | querice or).                   |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
| ē                                | Sequentially list co                         | nditions,             | b. Oue to (o  | as a consec                              | guerica offi:                  |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
|                                  | cause. Enter Under<br>Cause (Disease or      | erlying -             |   |  |                                |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
| Y                                | that initiated events<br>resulting in death) | s<br>Last             | c. Due to (o  | r as a consec                            | uence of):                     |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
|                                  |  |                       |   |  |                                |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
| Medical Examine                  |  |                       | d   |  |                                |                              |   |                            |                           |                                  |                      |                             | -  |                            |               |
| M                                | IF FEMALE:                                   |                       | 220 16 1100 01100   |  |                                |                              |   |                            |                           |                                  |                      | 13.51                       |  |                            |               |
| - 1                              | 23b. Was deceden<br>in the past 12           | t pregnant<br>months? |   | h 2∐Feta                                 | al death 3                     | □Ectopic p                   |   |                            |                           |                                  |                      | 23d. Date<br>Mor            | e of delive                                  |                            | Year          |
| 3                                | 1 Tyes 2                                     | □No                   | 4☐Pregnai<br>9☐Unknov                                       | nt at time of o                          | death 5                        | Other (s)                    | pecify)   |                            |                           |                                  |                      | 19101                       |  | Day                        | 1041          |
| -                                | 9 Unknown                                    |                       |   |  |                                |                              |   |                            |                           |                                  |                      | 1                           |  |                            |               |
| completed by Fligstera           | Part II. Other signi                         | ficant condition      | ons contributing to dea                                     | th but not res                           | sulting in the                 | underlying (                 | cause give  | en in Part I               |                           | 23e. Did                         | tobacc               | o use contr                 | bute to the                                  | he cause of d              |               |
| 3                                | Autism                                       |                       |   |  |                                |                              |   |                            |                           | 1                                | ] Yes                | 2 🗆 No                      | 3 Prot                                       | oably 4 🕅                  | Jnknown       |
|                                  |  |                       |   |  |                                |                              |   |                            |                           | 24a. Wa                          | s an                 | 24b. V                      | Vere auto                                    | psy findings               | available     |
| Ē                                |  |                       |   |  |                                |                              |   |                            |                           | , per                            | opsy<br>formed       | ? d                         | leath?                                       | mpletion of c              | ause ol       |
|                                  | 25 Was sacs sat-                             | red to media-         |   |  |                                |                              |   | 00.5:                      | -40                       | 100 Yes                          |                      | No 1                        | Yes  | 2 No                       |               |
| 200                              | 25. Was case reference examiner?             |                       | Hospital:   |  | len:a                          |                              | On Othe   |                            |                           | Check only                       |                      |                             |  |                            |               |
| 2                                | 1 to Yes 2 ☐<br>27. Manner of Deat           |                       | 1 □ In  |  | 28b. Time                      |                              | 0^  | 4   140                    |                           | me 5 Res<br>28d. Describe        |                      |                             |  | y) AT S                    | CENE          |
| 5                                | 1 Natural                                    | 5 Pendin              | ng (Month,  | Day Year)                                | Injury                         |                              | 28c. Injury<br>Work   |                            |                           | Zou. Describe                    | HOWII                | qury occurr                 | <b>9</b> 0                                   |                            |               |
| Š                                | 2 ☐ Accident<br>3 ☐ Suicide                  | investig<br>6 ☐ Could | not be  |  |                                | М                            |   | Yes 2□                     | -                         |                                  |                      |                             |  |                            |               |
|                                  | 4  Homicide                                  | determ                | ined 256. Place o   | f Injury - At h<br>j, etc. <i>(Speci</i> | iome, farm, s<br>ify)          | treet, factor                | y, office   |                            | 1                         | 281. Location<br>City or To      |                      |                             | er or Rura                                   | al Route Num               | ber,          |
| נ                                |  |                       |   |  |                                |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
| medical cel uncanon.             | 29a. Certifier<br>(Check only<br>one)        | 1 Certifyin           | ng Physician: To the b<br>Examiner: On the bas<br>and manne | is of examina                            | owledge, dea<br>ation and/or i | ath occurred<br>nvestigation | at the time, in my of   | ne, date ar<br>pinion, dea | nd place, a<br>ath occurr | and due to the<br>ed at the time | e cause<br>e, date a | (s) and mai<br>and place, a | nner as s                                    | tated.<br>o the cause(s    | .)            |
| Š                                | 29b. Signature and                           | title of certifie     |   | a stateu.                                |                                | 29                           | c. License  | number                     |                           |                                  | 294 1                | Date signed                 | (Month                                       | Day Year                   |               |
|                                  | <b>&gt;</b> / \                              | , \                   | _   |  |                                | 23                           |   | .M.E                       |                           |                                  | DE                   |                             |  |                            |               |
|                                  | hy   | ~                     | , mid   |  |                                |                              | 0.0   | • 11 • E                   |                           |                                  | DE.                  | N. I                        | 0, 2   | (00)                       |               |
|                                  |  |                       | who completed cause   | of death (Ite:                           | m 23a) (Type                   | Print)                       | rrr<br>T  | ВДТ Т                      | TMODI                     | E, MARYI                         | .Δ\π                 | 2120                        | 1  |                            |               |
|                                  | LIN  |                       |   |  |                                | M DIKI                       | و النات   | DALL.                      | TINNI                     | דו איבור דו                      | TEATIN               |                             | <u>.                                    </u> |                            |               |
| •                                | 31. Date filed (Mon                          |                       |   | gist ar's Sign                           | ature                          |                              |   |                            |                           |                                  |                      |                             |  |                            |               |
|                                  |  | UEU                   | 1 3 2005  | RELECT                                   | 15.                            | Son                          | A.  |                            |                           |                                  |                      |                             |  |                            |               |

State

Registrar

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|---------------------------|---|------------------|-----------------|
|                           | State of Maryland / Department of Health and Mental                         | Hygiene          | 10000           |
|                           | State of Maryland / Department of Health and Mental<br>Certificate of Death | Reg. No.         | 42008           |
| lame (First, Middle, Last | 2. Date   | of Death         | 3 Time of Death |

|           | ı |
|-----------|---|
| Physician | ı |
| /Medical  | ŀ |
| Examiner  |   |
|           | ı |

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural," or items 23s or 28s-f show any injury or other traumatic event, the Modical Externment in that be notified at actions of the continued at an other traumatic event, the Modical Externment in that be notified at actions.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

| 2/1   | 4                         | □ Registrer   |                       |   | Cer  | illicate of  | Dealli                                   |                                   | Reg. No.                     | tank tank                                | 1 5000  |
|-------|---------------------------|---|-----------------------|---|--|--|--|-----------------------------------|------------------------------|--|---|
| ciar  | 1                         | 1. Decedent's Name Marion   | e (First, Middl<br>Su |   |  |  |  | 2. Date of De<br>Month<br>Decembe | Day                          | Year<br>005                              | 3. Time of Death 2:10AM                             |
| dica  |                           |   |                       | n, give street and number)                              |  | 4b City Town o   | r Location of Deat                       |                                   |                              | nty of Dear                              |   |
| ine   |                           |   |                       |   |  | Tr.J.  | Princes                                  |                                   |                              | •  |   |
|       |                           | 31346 Pe  |                       |   | e (In yrs. last birthday)  | If Under 1 Year  | If Under 24 Hrs                          |                                   | Some                         |  | the loss (State or Fornisa                          |
| al    |                           |   |                       | 1 DM NOTE   |  | Months Days  | Hours Min.                               | (Month, Da                        | y, Year)                     |  | thplace (State or Foreign<br>ountry)                |
| or    | -                         | 219-92-0  |                       | 5   | 5 Yrs.   |  |  | 02/24/                            | 1950                         | Mar                                      | yland   |
|       | -                         | Usual Residence of<br>10a. State  | 10b. County           |   | 10c. City, Town or Loc   | ation  |  |                                   |                              |  | 10d. Inside City Limits                             |
|       | .                         | MD  | Somer                 |   | Eden   |  |  |                                   |                              |  | 1/2 Yes 2 □ No                                      |
|       | 5                         | FID   | Somer                 | Set   |  | Princes  | s Anne                                   |                                   |                              |  | A les 2 livo  |
| 1     | runeral Director          | 10e. Street and Nur   | mber                  |   |  | 10f. Zip Code  | 21853                                    | :                                 | 10g. Citizen o               | of What Co                               | ountry?   |
| 1     | <u> </u>                  | 31346 E   | eggy N                | Neck Road   |  | 2  | 1822                                     |                                   | USA                          |  |   |
|       | e                         | 11. Marital Status  |                       | 12. Was Decedent<br>Armed Forces?                       | Ever in U.S. 13. V   | Vas Decedent of H  | dispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or No                 | )- 14. F                     |  | erican Indian,                                      |
| į.    | 2                         | 1 Never Marri   | ied 2∏ Mar            | ried 1 Yes 2  | 10   | _ \ /  |  | to moan, etc.)                    |                              | lack, Whit                               | le, etc.  |
| 1     | à                         | Widowed   | 4 Divorced            | Year or Dates:  | '  | Yes 2 No   | Specify:                                 |                                   | Spe                          |  | nite  |
|       | Completed                 | (Fn.e.)   | 15. Deceder           | nt's Education  | 16a. Deced   | ent's Usual Occup  | oation<br>during most of wo              |                                   | 16b. Kind of                 | Business                                 | /Industry   |
|       | <u>d</u>                  | Elementary/Seco   |                       | st grade completed) College (1-4or 5                    | life. D  | O NOT use retire   | d) most of wo                            | irking                            |                              |  |   |
|       | Ó                         | 10  | , (,                  | none  | · 1  | etary  |  |                                   | Cleri                        | ca1                                      |   |
|       | De.                       | 17. Father's Name   | (First, Middle,       |   |  |  | 18. Mother's Na                          | me (First, Middle                 |                              |  |   |
|       | 0                         | Hammond H   | Betts                 |   |  |  | Kathryn                                  | V. Nels                           | on                           |  |   |
| 11    | -                         | 19a. Informant's Na   |                       | ship (Type, Print)                                      | 19b. Mailin  | a Address (Street  | and Number or R                          |                                   |                              | vn. State                                | Zin Code)   |
|       |                           | Tracy War   | rthen/c               | laughter  |  |  | y, Delma                                 |                                   | 1875                         | ,  | F   |
|       | -                         | 20a. Method of Disg   |                       | addirect  | 20b. Place of Dispos   |  | ) , DCIMA                                | Date                              |                              | n - City or                              | Town, State   |
|       |                           | 1 🗆 Burial 2  | Cremation             | 3 Removal from State                                    | cemetery, cren   | atory`or other pla   | - T                                      |                                   |                              | •  |   |
|       | 4                         | 4 Donation  | -                     |   | The second secon | The state of the s |  |                                   | Salisb                       | ury,                                     | Maryland  |
| once. |                           | Signature of Fu   | ineral Service        | trentee 4   | Hi   | Name and Addre<br>nman Fun   | eral Hom                                 | e                                 |                              |  |   |
| ٥,    | 4                         | ENLLS   | MI                    | Marian  | 100295 11  | 673 Some   | rset Ave                                 | Princ                             | ess An                       | ne, l                                    | т 21853   |
|       | /                         | 23a. Part1. Enter the shock, or hea   | he disease, e         | complications that caused<br>tonly one cause on each li | the death. Do not entented   | er the mode of dyi   | ng, such as cardia                       | c or respiratory a                | rrest,                       |  | Approximate<br>Interval Between                     |
| n     | 1                         | Immediate Cause disease or condition  | (Final                | Al/   | TE MY  | OCARI  | SIAL 1                                   | NFARC                             | TION                         | ,  | Onset and Death                                     |
| al    |                           | resulting in death)   |                       |   | a consequence of):   |  |  |                                   |                              |  | 3 11/11/01/-2                                       |
| er    |                           |   |                       |   | BETES  | ME   | LLITY                                    | S                                 |                              |  | 3 YEARS   |
|       | ē                         | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde<br>Cause (Disease or | nditions,<br>nmediate | Due to (or as   | a consequence of):   |  |  |                                   |                              |  |   |
|       |                           | Cause (Disease or that initiated events   | injury                | <b>S</b> .  |  |  |  |                                   |                              |  |   |
|       | Examiner                  | resulting in death)   | Last                  | Due to (or as   | a consequence of):   |  |  |                                   |                              |  |   |
|       | g                         |   |                       |   |  |  |  |                                   |                              |  |   |
| 1     | an/medical                |   |                       | U   |  |  |  |                                   |                              |  |   |
| 3     | S                         | IF FEMALE:<br>23b. Was deceden  | t prognant            | 23c. If yes, outcome                                    | of pregnancy   |  |  |                                   | 234                          | Date of de                               | livery  |
|       |                           | in the past 12  | months?               | 1 ☐Live birth<br>4 ☐ Pregnant at                        | 2 Fetal death 3 time of death 5  | Ectopic pregnance<br>Other (specify)   | У  |                                   |                              | Month                                    | Day Year  |
|       | S                         | 1 □ Yes 2 <b>[</b><br>9 □ Unknown   | ZNo<br>I              | 9□ Unknown  |  | - Cirio (opeciny) _  |  |                                   |                              |  |   |
| Č     | Completed by Physici      | Part II. Other signif   | ficant conditi        | ons contributing to death b                             | ut not resulting in the ur   | derivina cause an  | ven in Part I.                           | 23e. Did 1                        | tobacco use co               | ontribute to                             | o the cause of death?                               |
| 13    | 6                         | CHRO  |                       | DBSTRUC   |  |  | DISEAS                                   | SE 117                            | Yes 2□No                     | 3 □ P                                    | robably 4 DUnknown                                  |
|       | ere                       | 141.000   |                       | 1101  | OF DICE  | -100   |  |                                   |                              |  |   |
|       | ğ                         | MAPEN   | ( ) EIV.              | SIVE HEA  | RT DISE  | 1756   |  | 24a. Was<br>auto                  | psy 24                       | <ol> <li>Were at<br/>prior to</li> </ol> | utopsy findings available<br>completion of cause of |
|       | ō                         |   |                       |   |  |  |  | 1 ☐ Yes                           | ormed?<br>2₽No               | 1 Yes                                    | 3 2 □ No  |
|       | ne                        | 25. Was case refer examiner?  | rred to medica        | 1   |  |  | 26. Place of De                          | ath (Check only                   | one)                         |  |   |
|       |                           | 1 ☑ Yes 2 □   | No                    | Hospital: 1   Inpatie                                   | ent 2 ER/Outpatien   | 3□ DOA Ott   | ner: 4 🗆 Nursing i                       | Home 5 Tesi                       | idence 6 🗆 0                 | Other (Spe                               | ocify)  |
|       | Ë.                        | 27. Manner of Deat  | th<br>5 ☐ Pendi       | 28a. Date of Inju<br>(Month, Da                         | ry 28b. Time of Injury   | 28c. Inju  | ry at                                    | 28d. Describe                     | how injury occ               | urred                                    |   |
| 1     | atic                      | 2 Accident  |                       | igation   | , ,  |  | Yes 2 □ No                               |                                   |                              |  |   |
| 1     | 2                         | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 ☐ Could deterr      | nined 200. Flace of Ing                                 | ury - At home, farm, stre  | et, factory, office  |  | 28f. Location (                   | Street and Nu.<br>wn, State) | mber or R                                | ural Route Number,                                  |
|       | e l                       | Tommoldo  |                       | building, et  | c. (Opechy)  |  |  | Only of 10                        | wii, Siale)                  |  |   |
|       | <u>a</u>                  | 29a. Certifier  | 1 Certifyi            | ng Physicien: To the best                               | of my knowledge, death   | occurred at the ti   | me, date and place                       | e, and due to the                 | cause(s) and                 | manner a                                 | s stated.   |
| :     | Medical Certification; 10 | (Check only one)  | 2 Medice              | Exeminer: On the basis o<br>and manner st               | t examination and/or invated.  | estigation, in my o  | opinion, death occ                       | urred at the time,                | date and plac                | e, and due                               | e to the cause(s)                                   |
| 1     | Σ                         | 29b. Signature and  | title of certific     | er 7  |  | 29c. Licens  | se number                                | 2/2                               | 29d. Date sig                | ned (Mont                                | th, Day, Year)                                      |
|       |                           |   |                       | 10  | - er/  | 10 1   | 46                                       | Y62                               | DECE                         | -MBE                                     | K 09, 2005  |
|       | -                         | 30. Name and add  | ress of persor        | who completed cause of o                                | eath (Item_23a) (Type,   |  |  |                                   |                              |  | -   |
|       |                           | M.St  | HIRAT                 | 4, M.D. 3   | 1575 V   | INTER  | PLACE                                    | PARK                              | WAY,                         | IN                                       | 21804   |
| State | е                         | 31. Date filed (Mon   | nth, Day, Year        | ) 32. Region  |  |  |  |                                   |                              |  |   |
| stra  | r                         |   | DEC :                 | 1 2 2005  | er's Signature   | good !   |  |                                   |                              |  |   |

Registrar

DEC 1 2 2005

Jose Tellez 05-08238 NJM

| ,OZ          | <b></b>  |                   | 1 - For<br>State<br>Registrar   | State of Maryla   | -   | artmen<br>rtificat                    |                         |                               |              |  | Rag. No.           |                              | 4200                                 | 9                  |
|--------------|--|-------------------|---|---|---|---------------------------------------|-------------------------|-------------------------------|--------------|--|--------------------|------------------------------|--------------------------------------|--------------------|
|              | Physici  | an                | Decedent's Name (First, Middle, L   |   |   |                                       |                         |                               |              | <ol><li>Date of De<br/>Month</li></ol> | ath<br>Day         | / Year                       | 3. Time of D                         | eath               |
|              | /Medio   | al                | JOSE GUADALUP  4a. Facility Name (If not institution, gi  |   |   | 4h City                               | Town or                 | Location of                   |              | ecembe                                 |                    | 2005<br>County of Death      | 1258                                 | - M                |
|              | Examir   | er                | Peninsula Region  |   | tor   |                                       | alisb                   |                               | Death        |  |                    |                              |                                      |                    |
|              | Funeral  |                   | 5. Social Security Number 6.  | Sex 7. Age (In y  | rs. last birthday,                                  | If Under                              | r 1 Year                | If Under:                     | 24 Hrs. Min. | B. Date of Bird<br>(Month, Da          | th                 | icomico<br>9. Birth          | place (State or F                    | Foreign            |
|              | Director   |                   | unk   | ¹XM 2□F 15  | Yrs.  | Months                                | Days                    | Hours                         |              |  | 5,                 | 1990 Me                      | xico                                 |                    |
|              | A .  |                   | Usual Residence of Decedent  10a. State 10b. County   | 10c.  | City, Town or L                                     | ocation                               |                         |                               |              |  |                    |                              | 10d. Inside City                     | Limits             |
|              | Manylan<br>f show  | ៦                 | MD Somers   |   | isfiel  |                                       |                         |                               |              |  |                    |                              | 1 🗆 Yes 2                            |                    |
|              | within 72 hours effer death with the Maryland<br>ene.<br>then "neturel", or Items 23e or 28e-f show<br>he Madical Exercites crass be notified at   | Funeral Director  | 10e. Street and Number<br>27030 Joe Lew   |   |   | 10f. Zip                              | Code<br>817             |                               |              |  | 10g. Cit           | izen of What Cou             | ntry?                                |                    |
|              | death<br>ms 23   | era               | 11. Marital Status  | 12. Was Decedent Ever in                                  | U.S. 13.  | Was Dece                              | dent of His             | spanic Ori                    | gin? (Spec   | ify Yes or No                          | )-                 | 14. Race - Ameri             |                                      |                    |
| 9            | or Ite   | 正                 | 1X Never Married 2 ☐ Married  | Armed Forces? 1 ☐ Yes 2 ☐ X lo If Yes, Give               |   | 1 ☐ Yes                               |                         |                               |              |  |                    | Black, White,<br>Specify: Hi |                                      | •                  |
| 21215-0036   | urel',   | d by              | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:  |   |                                       |                         |                               | MCA.         |  |                    |                              |                                      |                    |
| 5            | "net   | Completed         | 15. Decedent's l<br>(Specify only highest g   |   | 16a. Dece   | dent's Usua<br>kind of wo<br>DO NOT u | al Occupa<br>ork done d | ition<br>lu <i>ring m</i> osi | t of workin  | g                                      | 16b. K             | ind of Business/Ir           | dustry                               |                    |
| 12           | withi<br>Bne.<br>then  | dwo               | Elementary/Secondary (0-12)   | College (1-4or 5+)  |   | dent                                  | 50 10.400)              |                               |              |  | Edi                | cation                       |                                      |                    |
| d            | should be filed<br>nd Mental Hygid<br>marked other<br>imatic event, II   | Be C              | 17. Father's Name (First, Middle, Las   | st)   |   | 40110                                 |                         | 18. Mothe                     | r's Name     | (First, Middle                         |                    |                              |                                      |                    |
| 'lan         | ould be<br>Mental<br>Marked o  | ToB               | Celestino   | Tellez  |   |                                       |                         | Ana                           | Mar          | ia Bed                                 | ceri               | cil                          |                                      |                    |
| Maryland     | 2 2 2 2  |                   | 19a. Informant's Name/Relationship  |   |   | -                                     |                         |                               |              |  | -                  | r Town, State, Zi            |                                      |                    |
|              | 1 and 1<br>Health<br>em 27   |                   | Celestino Tell  | <del></del>   |   |                                       |                         | wis                           |              |  |                    | eld, M                       |                                      | 7                  |
| ore          | ges 1 au<br>t of Hea<br>If Item<br>or othe   |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3   | Removal from State  | <ul> <li>Place of Disp<br/>cemetery, cre</li> </ul> | matory or c                           | other place             | i                             | Da           | ite                                    |                    | ocation - City or T          |                                      |                    |
| Baltimore,   | t. Partmen<br>rtant:   |                   | 4 Donation 5 Other (Spec  |   | inapec  |                                       | •                       |                               |              |  |                    | pecuar                       |                                      | ico                |
| Bal          | permit. Pages. Depertment of h Important: If Ite eny Injury or of  |                   | 21. Signature of Egneral Service Lic  | ensee   |   |                                       |                         |                               |              | way Mels<br>e City,                    |                    | uneral Hor<br>851            | e, P.A.                              |                    |
| 8760,        | Physician /Medical Examiner  physicien end p | sal Examiner      | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a cons                                   |   | rc P                                  | tor                     | ce                            | igic         | urie S                                 | 5                  |                              | Onset and De                         |                    |
| P.O. Box 687 | death certific<br>e attending p<br>od for use as   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pre 1                             | etal death 3  | □Ectopic pi<br>□ Other (s.c           |                         |                               |              |  |                    | 23d. Date of deliv<br>Month  | ery<br>Day Ye                        | ar                 |
|              | 8 2 9  | þ                 | Part II. Other significant conditions   | contributing to death but not                             | resulting in the (                                  | underlying o                          | cause give              | in Part I                     |              |  | tobacco i<br>Yes 2 | use contribute to            | he cause of dea<br>bably 4 □Uni      |                    |
| Records,     | The law requir<br>ete has been si<br>pege 2 should   | Completed         | <u> </u>  |   |   |                                       |                         |                               | -            | 24a. Was<br>auto<br>perio<br>1 X Yes   |                    | death?                       | opsy findings av<br>empletion of cau | railable<br>use of |
| of Vital     | ysician: The<br>is certificete ha<br>director, pege  | Bec               | 25. Was case referred to medical examiner?  |   | 77.5  |                                       |                         | 26. Place                     | of Death     | Check only                             |                    |                              |                                      |                    |
| ₹            | Physician:<br>rthis certific<br>ral director,  | ၉                 | 1XXYes 2 No   | <del></del>   | <b>XX</b> P/Outpatie                                |                                       |                         | 4   190                       |              |  |                    | 6 □Other (Speci              | (y)                                  |                    |
| Ë            | ding Ph<br>h.<br>After thi<br>funeral  | -io               | 27. Manner of Death  1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day Year                   |   | ( a                                   | 28c. Injury<br>Work     |                               |              | 8d. Describe                           | how inju           |                              | dand cu                              | 1                  |
| Division     | Attending r death. ector: After by the fune  | Certification:    | 2 Accident investigat 3 Suicide 6 Could not   | be 390 Place of Initial A                                 | ibomo form o  |                                       |                         | ∕es 2⊠                        | •            | 8f Location /                          | Stroot or          |                              |                                      |                    |
| .≥           | or A<br>efter<br>Direction by  | ertif             | 4 Homicide determine  | 28e. Place of Injury - A building, etc. (Sp.              | ecify)  | SUSP                                  | у, опісе                |                               | -            | 3 City of To                           | wn State           | 7                            |                                      | эг,                |
|              | To the Hospitel or Attend within 24 hours efter death To the Funeral Director: completely filled in by the t   | edical C          | (Check only 2 Thedical Ex   | Physician: To the best of my aminer: On the basis of exam | knowledge, dea                                      | th occurred                           | at the tim              | e, date an                    | nd place, a  | nd due to the                          | cause(s            | and manner as                | stated.                              |                    |
|              | o the<br>ithin 2<br>o the<br>ample   | Med               | 29b. Signature and title of certifier   | and manner stated.  |   | 29                                    | c. License              | number                        |              |  | 29d. Da            | te signed (Month,            | Day, Year)                           |                    |
|              | F 3 F 8  |                   | Dr. A   | ·   | 200L  |                                       |                         |                               |              |  |                    |                              |                                      |                    |
|              |  |                   | 30 Name and address of person wh  | o completed cause of death (                              | Item 23a) (Tune                                     | . Print)                              | OC                      | ME                            |              |  | necei              | mber, 7,                     | 2005                                 |                    |
| C.           | H.a  |                   | PATRICIA DO   | SALICA-Pall   | & Kmo   |                                       | l Pe                    | nn St                         | reet         | Balt:                                  | imor               | e, Maryl                     | and 212                              | 01                 |
|              | St<br>Regist   |                   | 31. Date filed (Month, Day, Year)   | 2005  | gnature   | Coulle                                | ,                       |                               |              |  |                    |                              |                                      |                    |

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** December 11, 2005 Gerald L. Taylor 3:05 p. /Medical 4c. County of Death
Frederick 4a. Fecility Name (If not institution, give street and number)

Kline Hospice House 4b. City, Town, or Location of Death **Examiner** Mt. Airy | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State Country) | 9. Birthplace (State Country) | 1936 | Maryland | 1936 | Maryland | 1936 | Maryland | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 1936 | 193 9. Birthplace (State or Foreign 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** 102M 2□F 69 217-30-7144 Director Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside/City Limits r than "natural", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at Frederick 1 Yes 2 No Frederick Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 8015 Dustin Drive U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 12 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Lab technician Atlantic research 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Ruth K. Thomas Ernest H. Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8015 Dustin Drive, Frederick, Maryland Ruth Taylor - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/14/2005 Thurmont, Maryland Blue Ridge Cemetery \* 4 ☐ Denation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland Varon Celmille 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and eath Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ⊌nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has page 5 autopsy performed 2 № No 1 Yes 2 🗌 No 1 ☐ Yes the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPILE Certification; To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 044184 12/12/05 2. HEGGE, MP FREDERIUM MD 21702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ohnsobromas 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 13 2005 Registrar

Andrew Ursin 05-08259 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#3, perM (331,1/10/05 TI
State of Maryland / Department of Health and Mental Hygiene d11 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ursin 4:45 <del>т</del>ам Andrew 2005 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly Hours Min. May 28, 1956 If Under 1 Year Months Days 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**√**M 2□F 49 220-70-7267 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "naturel", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2√2 No MD Charles Nanjemoy Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20662 7800 Navajo Place USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than College (1-4or 5+) Elementary/Secondary (0-12) Technical Manager Firearms permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other important: other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lydia Ursin Robert Ursin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7800 Navajo Place, Nanjemoy, MD 20662 <u> Carol Ursin/Wife</u> 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Brinsfield-EChols 12/11/05 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Echale AREHART-ECHOLS FUNERAL HOME, P.A. aun PLATA MD 20646 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in dealh) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 2 No 1 Yes 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No hes autopsy performed? this certificete 2 No 1 Yes or Attending Physicien: director. 25. Was case referred to medical examiner?

10 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of Injury (Mgnth, Pay Year) Certification: 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural deeth. 1 Tes 2 Accident 05 e filled in by the Director 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours efter 20662 loon the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and little of gertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
DEC 1 2 2005

wekt

en

2. Persistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

OCME

December 8, 2005

State of Maryland / Department of Health and Mental Hygiene - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Albert George Werkheiser, Sr. 8, 2005 4c. County of Death December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5a Lisbury reninsula Wiconico Regional Mediant Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania **Funeral** Months Days Hours 1**X**IM 2□ F Min. Director 218-34-7654 70 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State rithen "naturel", or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Funeral Director Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 East State Street 21875 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Yes 2 No Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Never Married 2 Married Unk. 1 ☐ Yes 2 🗓 No Specify: White Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator Cleaning Service if item 27 is marked other or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 86 nd Mental I Pages 1 end 2 should be Frank Charles Werkheiser, Sr. Gertrude Merwarth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Depertment of Health er Importent: If Item 27 ie eny injury or other treu once. Albert G. Werkheiser, Jr. / Son 114 Lillian Street, Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Hebron Cemetery 4 □ Donation 5 □ Other (Specify) 12/12/2005 Hebron, Maryland 21. Signature of Fuperal Service License Zeller Funeral Home, P. O. Box 3171 1212 Old Ocean City Road, Salisbury, MD 21802 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HF /Medical Due to (or as a consequence of) Examiner ASCVD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed ned by the attending physicien end deteched for use as the burial-transit FAILURG RENAL Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 □ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? the funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter deat To the Funeral Director: completaly filled in by the 6 Could not be determined 3 Suicide Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D57952 Don M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 106 Kilford ST. # 504B, Salis burn MD 21804 Babulal Das M-D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 2 2005

**ORIGINAL** 

|   |                  | -                | For<br>State<br>Registrar   | State of                                    | Marylan                           | d / Depa<br><i>Cei</i> | artment of H                            | lealth and<br>Death                | d Mental Hyg                                | giene<br>Reg. No.           | )5 4                     | 2013   |  |
|---|------------------|------------------|---|---|-----------------------------------|------------------------|---|------------------------------------|---|-----------------------------|--------------------------|--|--|
| Dhi   |                  |                  | 1. Decedent's Name (First, Middle   | e, Last)                                    |                                   |                        |   |                                    | 2. Date of Dea<br>Month                     | ath<br>Dav                  | Year                     | 3. Time of Death                                   |  |
|   | /sicia<br>ledica |                  | Lewis Emmert W  |   |                                   |                        |   |                                    |   | 15 <sup>Day</sup>           | 2005                     | 04:25 AM   |  |
| Exa   | amine            | er               | 4a. Facility Name (If not institution Homewood Retire   | -   |                                   |                        | 4b. City, Town, or William              |                                    | eath  |                             | inty of Death<br>shingto | on.  |  |
| Fund  |                  | ę.               | 5. Social Security Number   |   | 7. Age (In yrs.                   | last birthday)         | If Under 1 Year                         | If Under 24 I                      |   |                             | 9. Birthp                | lace (State or Foreign                             |  |
| Fune<br>Direc   |                  |                  | 158-07-9943   | 1 <b>∑X</b> M 2 ☐ F                         | 89                                | Yrs.                   | Months Days                             | Hours N                            | Min. (Month, Day 03/28/1                    | y, Year)<br>.916            | Coun                     | MD   |  |
| pu »  |                  | -                | Usual Residence of Decedent  10a, State 10b, County   |   | 10c Cit                           | y, Town or Lo          |   |                                    |   | 10d. Inside City Limits     |                          |  |  |
| aryla   | 20.00            | 5                | MD Washi  | ngton                                       |                                   | gersto                 |   |                                    |   |                             | 1                        | 1 X Yes 2 No                                       |  |
| the M   | Della            | rect             | 10e. Street and Number  |   | 1100                              |                        | 10f. Zip Code                           |                                    |   | 10g. Citizen                | of What Coun             | try?   |  |
| 3 with  | al de            |                  | 323 N. Potomac  | Street                                      |                                   |                        | 21740                                   | )                                  |   | US                          |                          |  |  |
| Idiyidili 4 14 13-0000<br>2 should be filed within 72 hours after death with the Maryland<br>and Mental Hygiene.<br>Is marked other than "neturel", or flema 23e or 28e-f ehow  |                  | Funeral Director | 11. Marital Status  | 12. Was Dece                                | dent Ever in U                    |                        | Was Decedent of H                       | ispanic Origini<br>an, Mexican, Pi | ? (Specify Yes or No-<br>uerto Rican, etc.) |                             | Race - Americ            |  |  |
| s afte  | 9                | by Fu            | 1 ☐ Never Married 2 ☐ Marr<br>3 ☐ Widowed 4 ☐ Divorced  | If Yes, Giv                                 | е                                 |                        | 1 ☐ Yes 2 No                            | Specify:                           |   |                             |                          | nite   |  |
| hour tural  | 2                | ed b             |   | Year or Da                                  | 1185.                             | 16a. Dece              | dent's Usual Occup                      | ation                              |   | 16b. Kind o                 | of Business/Inc          | dustry   |  |
| n   | Medi             | Completed        | (Specify only higher<br>Elementary/Secondary (0-12)   | st grade completed)                         | -4or 5+)                          | (Give                  | kind of work done of DO NOT use retired | during most of<br>d)               | working                                     |                             |                          |  |  |
| ad will   |                  | Com              | 12  | College (1<br>5 +                           | 10.01,                            | Ele                    | ctrical E                               |                                    |   |                             | Constru                  | ıction   |  |
| tal Hy  | • v              | Be               | 17. Father's Name (First, Middle,   | -   |                                   |                        |   |                                    | Name (First, Middle,<br>sie Rose E          |                             | name)                    |  |  |
| hould<br>d Mer  | Hatic            | ၉                | Lewis Peters W  |   |                                   | 10h Maili              | na Addrass /Streat                      |                                    | r Rural Route Numbe                         |                             | um State Zin             | Code   |  |
| Dallillore, Mal ylallo 4 14 15-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. important: If item 27 is marked other than "natural", or itema 23e or 28e-1 ehov | trau             |                  | Philip C. Wing  |   |                                   |                        |   |                                    | et, Hagers                                  |                             |                          |  |  |
| S 1 ar  | er l             | 1                | 20a. Method of Disposition  |   | 1 0                               | Place of Dispo         | osition (Name of matory or other place  | ce)                                | Date  | 20c. Location               | on - City or To          | wn, State  |  |
| Definition Pages Department of mportant: if it  | יין אַ           |                  | 1   Burial 2 □ Cremation  Donation 5 □ Other (S   |   | State                             | •                      | 1 Cemeter                               | 1 1                                | /19/05                                      | Hager                       | stown,                   | MD   |  |
| ermit.  | eny inj          |                  | 21. Signature of Funeral Service  | Licensee                                    | 2                                 | 22                     | 2. Name and Addre                       | ss of Facility                     | Gerald N.                                   | Minni                       | ch Fune                  | eral Home  |  |
| 1 40E   | a a              |                  | 10 on-7   | 7   |                                   |                        |   |                                    | treet, Hay                                  |                             | wn, MD                   |  |  |
|   | 32               |                  | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final                | only one cause on ea                        | aused the deat                    | h. Do not ent          | ter the mode of dyin                    | ig, such as can                    | diac or respiratory ar                      | rest,                       |                          | Approximate<br>Interval Between<br>Onset and Teath |  |
| Physic<br>/Medi   |                  |                  | disease or condition<br>resulting in death)   | a   | or to conseq                      |                        | KLUNE                                   |                                    |   |                             | -                        | WKS  |  |
| Exami   |                  |                  |   | Due to (                                    | OF TO CONSEQ                      | CON A                  | DN                                      |                                    |   |                             |                          | (1) cay  |  |
|   |                  | Je.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (                                    | or as conseq                      |                        |   |                                    |   |                             |                          | 1 -  |  |
| acuted  | transi           | Examin           | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                               | c(  | /)17                              |                        | E EN                                    | 15noc                              | 17150                                       |                             | (                        | elek)  |  |
| ate be exi<br>hysician a  | purial           |                  | resulting in doutin, cast   | Due to (                                    | or as a conseq                    | uence or):             |   |                                    |   |                             |                          |  |  |
| ncate<br>phys   | s the            | edicai           |   | d   |                                   |                        |   |                                    |   |                             |                          |  |  |
| C Certil  | nse a            | Physician/Me     | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, out                            |                                   |                        | Te                                      |                                    |   | 23d.                        | Date of delive           | ry   |  |
| death death   | of be            | icia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  |   | inth 2 ☐ Feta<br>ant at time of d |                        | Ectopic pregnancy Other (specify)       | '                                  |   |                             | Month                    | Day Year   |  |
| the the   | etach            | Phys             | 9 Unknown   |   |                                   |                        |   |                                    | F   |                             |                          |  |  |
| res th  | 90               | ۾                | Partil Other significant condition  | HAUNC                                       | eath but not res                  | sulting in the u       | inderlying cause giv                    | en in Part I.                      | 23e. Did to                                 |                             |                          | e cause of death?                                  |  |
| w requires to been signe  | hould            | eted             | A Donas   | to  | 14-1                              | ZC                     |   |                                    |   | -                           |                          |  |  |
| has law   | 96 2             | Completed        | HIMIGH  | FIBACC                                      | MILA                              |                        |   |                                    | — 24a. Was autop                            | rmed2                       | prior to cor<br>death?   | osy findings available<br>appletion of cause of    |  |
| clan: The sertificate   | or, pa           |                  | 25. Was case referred to medica   |   |                                   |                        |   | 26 Place of                        | 1 ☐ Yes  Death   Check only o               | 20 No                       | 1 🗆 Yes                  | 2□ No  |  |
| ysicia<br>is cer  | direct           | To Be            | examiner?<br>1 ☐ Yes 2 No   | Hospital:                                   | npatient 2                        | ER/Outpatier           | nt 3 DOA Oth                            | on /                               | ng Home 5 Resid                             |                             | Other (Specify           | ′)   |  |
| ng Phy<br>fter thi  | nerai            |                  | 27. Manner of Death  1 Natural 5 Pendir   | 28a. Date of                                | of Injury<br>h, Day Year)         | 28b. Time o            | f 28c. Injur<br>Wor                     | y at<br>k?                         | 28d. Describe h                             | now injury oc               | curred                   |  |  |
| tending<br>leath.<br>tor: After   | the to           | cati             | 2 Accident Investi  | gation and he                               |                                   |                        |   | Yes 2 □No                          |   |                             |                          |  |  |
| or Atte   | in by            | Certification;   | 4 Homicide determ   | inod 200. Flace                             | of Injury - At hing, etc. (Specif | ome, farm, sti<br>fy)  | reet, factory, office                   |                                    | 28f. Location (S<br>City or Tow             | Street and Nu<br>vn, State) | umber or Rura            | l Route Number,                                    |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending physician and                    | ely filled       | edicai C         | (Check only 2 Medical   | ng Physician: To the<br>Examiner: On the ba | asis of examina                   | owledge, deat          | h occurred at the tir                   | ne, date and pi<br>pinion, death o | lace, and due to the o                      | cause(s) and                | I manner as st           | ated. the cause(s)                                 |  |
| thin 2  | eldmo            | Med              | 29b. Signature and Mile of centries   | and manr                                    | ner stated.                       |                        | 29c. Licens                             |                                    |   |                             | gned (Month, i           |  |  |
| 135   | 8                |                  | 115/11  | li.   | Clas X                            | In the Top             |   | SDAZ                               | $\rightarrow$                               | 17                          | 10/2                     | or -   |  |
| 24  |                  | 1                | 30. Name and address of person  | MEUI  | e of death (Item                  | n 23a) (Type,          | Print) A                                | 11706                              | 1   | 11                          | 13/0                     | 1.1  |  |
| 0.1   |                  |                  | STEPHEN E   | METZAL.                                     | 1, Car                            | 7                      | 4) WON                                  | THEZN                              | Hue,  | HARA                        | STERRE                   | N, Wed   |  |
| Re  | Stat<br>gistra   |                  | 31. Date filed (Month, Day, Year)   | 2005 B                                      | agistrar's Signa                  | Mure -                 | Toursell )                              |                                    | ,   |                             | 917                      | 747  |  |

|  |                   | 1 - For State Registrar   | State of Maryland  |                          | artment of H<br>tificate of I                                    |   |                                       | giene<br>Reg. No       | UUU                             | 42014  |
|--|-------------------|---|--|--------------------------|--|---|---------------------------------------|------------------------|---------------------------------|--|
| Physici  | 20                | Decedent's Name (First, Middle, La  | · ·  |                          |  |   | 2. Date of De                         |                        | v Year                          | 3. Time of Death   |
| /Medi  |                   | George G. Wylan   | d Jr   |                          |  |   | Decemb                                | er 1                   | 1,2005                          | 10:31am M  |
| Examir   | ier               | 4a. Facility Name (If not institution, giv  |  |                          | 4b. City, Town, or   | Location of Deat                        | h                                     | 4c.                    | . County of De                  | ath  |
|  |                   | Suburban Hospi  5. Social Security Number 6. S  |  | de internation of        | Bethesd<br>If Under 1 Year                                       | a<br>If Under 24 Hrs                    | P. Data of Bir                        | M                      | ontgom                          | ery  |
| Funeral<br>Director  |                   | 1   | M 20F  | Yrs.                     | Months Days  | Hours Min.                              | 8. Date of Bir<br>(Month, Da<br>Sept  | y. Year)               | 919                             | inthplace <i>(State or Foreign</i><br>Sountry)<br>Baltimore,MI |
|  |                   | 577-09-2617 Usuel Residence of Decedent   | 8.6  |                          |  |   | осре                                  |                        | 717                             | Darcimore, Fil   |
| yland  |                   | 10a. State 10b. County  | 10c. City, To  | own or Lo                | cation   |   |                                       |                        |                                 | 10d. Inside City Limits  |
| Ma   | cto               | MD Montgom  | ery Beth   | esda                     |  |   |                                       |                        |                                 | Yes 2□No   |
| or 28  | Fe                | 10e. Street and Number  |  |                          | 10f. Zip Code  |   |                                       | 10g. Cit               | izen of What (                  | Country?   |
| be filed within 72 hours after death with the Maryland tall Hygiene. od other then "naturel", or iteme 23a or 28a-f ehow event, the Modical Examinar must be notified at | Funeral Director  | 5708 Marengo Rd   |  |                          | 20816  |   |                                       | Init                   | ed stat                         | es.  |
| teme   | - Lu              | 11. Marital Status  | 12. Was Decedent Ever in U.S. Armed Forces? 11dec4.  | 2 13. \                  | Was Decedent of H<br>f Yes, specify Cuba                         | ispanic Origin? (S<br>n, Mexican, Puen  | pecify Yes or No                      | )-                     | 14. Race - An<br>Black, Wh      | nencan Indian,   |
| s afte   | by F              | 1 ☐ Never Married 🏋 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 Tyes 2 No 10eC4. If Yes, Give Year or Dates: 25apr4  | _                        | 1 □ Yes Ž□ No  | Specify:                                |                                       |                        | Specify:                        |  |
| hour   | be be             | 15. Decedent's E  |  |                          | lastic Liquel Casus  | ation.                                  |                                       | 105 1                  | ind of Duning                   | White  |
| ad within 72 hours aff<br>giene.<br>er then "naturel", or<br>i, the Medical Exami  | Completed         | (Specify only highest gra   | de completed)  | (Give                    | lent's Usual Occup:<br>kind of work done o<br>DO NOT use retired | luring most of wo                       | rking                                 | 16D. K                 | ind of Busines                  | s/industry   |
| within<br>lene.<br>then  | E                 | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                          | Insuran  | •                                       | man                                   |                        | Insura                          | ınce   |
| e filed<br>Il Hygie<br>other<br>vent, tr   | BeC               | 17. Father's Name (First, Middle, Last,   | 4  |                          |  | 18. Mother's Nar                        | ne (First, Middle                     | , Maiden               |                                 |  |
| Mental   | To B              | George G. Wyland  | Sr.  |                          |  | Mary P                                  | laceman                               |                        |                                 |  |
| s 1 end 2 should<br>I Health and Mer<br>Item 27 te marke<br>other treumatic  | ļ                 | 19a. Informant's Name/Relationship (  | Type, Print) 1   | 9b. Mailir               | g Address (Street  | and Number or Ru                        | ıral Route Numb                       | er, City o             | or Town, State,                 | Zip Code)  |
| and 2 should be file<br>aith and Mental Hy<br>27 ie marked oth<br>er treumatic event   |                   | Kitty Wyland/Wife   | 2  | 5708                     | Marengo  | Rd, Bethe                               | sda,MD 2                              | 20816                  | 5                               |  |
| of Heal  |                   | 20a. Method of Disposition  | 20b. Place   | of Dispo                 | sition (Name of natory or other place                            |   | Date                                  |                        | ocation - City o                | r Town, State  |
| Dermit. Pages 1 e Department of Hes mportant: If Item any injury or othe   |                   | 1  Burial 2  □ Cremation 3  □ 4  □ Donation 5  □ Other (Specif  |  | e of                     | Heaven C   | em   12-                                | 15-05                                 | S11:                   | tor Snr                         | dee Mil  |
| permit. Pages to Department of Historians: If its eny injury or ot once.   |                   | 21. Signature of Funeral Service Lice   |  | 22                       | . Name and Addres  | s of Facility OS                        | eph Gawl                              | er's                   | Sons.                           | TNC  |
| #Q = 9 M   | 1. /              | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | . Dugge  | _   5                    | 130 Wisc   | <u>onsin Av</u>                         | e,N.W. W                              | lash:                  | ington                          | DC 20016   |
| Physician /Medical Examiner  Babhasicien and phusicien and the prinal-itransli   | al Examiner       | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Septic Shock Due to (or as a consequence) b. Bacterial Pne Due to (or as a consequence) c. Chronic Obstr Due to (or as a consequence) | umor<br>aunor            |  | nary Dis                                | ease                                  |                        |                                 | Onset and Death  |
| death certii<br>e ettending<br>ad for use a  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No   | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown   |                          | Ectopic pregnancy  |   |                                       |                        | 23d. Date of d                  | elivery<br>Day Year  |
| The law requires that the drien law requires that the drien has been signed by the age 2 should be detached  | by P              | Part II. Other significant conditions of  | ontributing to death but not resulting   | in the ur                | nderlying cause give   | n in Part I.                            | 23e. Did t                            | obacco u               | ise contribute                  | to the cause of death?   |
| w require<br>been sk<br>should b   |                   |   |  |                          |  |   | '烃'                                   | Yes 2                  | □No 3□F                         | Probably 4 □Unknown  |
| law re<br>as be<br>2 sh  | Completed         |   |  |                          |  |   | 24a. Was                              |                        | 24b. Were a                     | autopsy findings available                                     |
| 9 6 6  | E                 |   |  |                          |  |   | autor<br>perfo                        | rmad?                  | death?                          |  |
| or Attending Physician: Thalier death.<br>Director: Afler this certificete<br>In by the funeral director. par  | BeC               | 25. Was case referred to medical  |  |                          |  | 26. Place of Dea                        | th Check only o                       |                        |                                 | 23.10  |
| Physician:<br>this certific<br>ral director.   | 10                | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital: 1 ☐ Inpatient 2 → ERV  | Outpatien                | t 3□ DOA Othe  | or: 4 Nursing H                         | lome 5 Resi                           | dence (                | 6 □Other (Sp                    | ecify)   |
| nding Physician:<br>th.<br>: After this certifice<br>s funeral director. p   | ü                 | 27. Manner of Death 1 ♣ Natural 5 ☐ Pending   | 28a. Date of Injury 28b<br>(Month, Day Year)   | . Time of<br>Injury      | 28c. Injury<br>Work  | at                                      | 28d. Describe I                       | now injur              | y occurred                      |  |
| Attending r death.   | catl              | 2 ☐ Accident investigation  |  |                          | M 1 (  | fes 2□No                                |                                       |                        |                                 |  |
| F 0 F 7  | Certification:    | 3 Suicide 6 Could not b 4 Homicide determined   | 28e. Place of Injury - At home,<br>building, etc. (Specify)  | farm, stre               | eet, factory, office   |   | 28f. Location (S<br>City or To        | Street an<br>vn, State | d Number or F<br>)              | Rural Route Number,  |
| To the Hospital or Attend<br>Within 24 hours after death<br>To the Funerel Director:<br>completely filled in by the 1  | Medical (         | 29a. Certifier Check only one) Cartifying Ph  | ysician: To the best of my knowled<br>niner: On the basis of examination<br>and manner stated.   | lge, death<br>and/or inv | occurred at the timestigation, in my op                          | e, date and place<br>pinion, death occu | , and due to the<br>rred at the time, | cause(s)<br>date and   | and manner a<br>I place, and du | as stated.<br>se to the cause(s)                               |
| To th<br>Withir<br>To th<br>comp   | ¥                 | 29b. Signature and title of certifier   | 0  |                          | 29c. License   | number                                  |                                       | 29d. Dat               | e signed (Mor                   | th. Day, Year)   |
| 10   |                   | 1 (   | 20m  |                          | Md O   | 040576                                  |                                       | De                     | cember                          | 14,2005  |
| •  |                   | 30. Name and address of person who  | completed cause of death (Item 23a   | a) (Type,                |  | 0.10370                                 |                                       | שפ                     | CCHIDEL                         | 14,2003  |
|  |                   | Ramin Oskoui M  |  |                          |  | Washing                                 | ton DC                                | 2001                   | 6                               |  |
| Sta  |                   | 31. Date filed (Month, Day, Year)   | 2. Registrar's Signature   | Aser                     | W  |   | yerorus (CR)                          | A COLUMN               |                                 |  |

10,31 FW

Wyliano, George izmios

| /Medi  | ian<br>cal          | 1. Decedent's Name (First, Middle, La<br>James  | R.  | Wi:  | lliams  |  | 2. Date of Deat<br>Month<br>DEC .  |  | 3. Time of Death O209 A   |
|--|---------------------|---|---|--|---|--|--|--|---|
| Exami  |                     | 4a. Facility Name (If not institution, giv<br>ANNE ARUNDEL MED  |   | <u> </u>   | 4b. City, Town, or<br>ANNAPC                    | Location of Death  |  | 4c. County of ANNE   |   |
| uneral<br>irector  |                     | 5. Social Security Number 212-04-5308  Usual Residence of Decedent  | Sex 7. Age (In yrs. 38  | last birthday)<br>Yrs.                                 | If Under 1 Year<br>Months Days                  | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth<br>(Month, Day,<br>Nov • 18   |  | Birthplace (State or Fore<br>Country)<br>Maryland   |
| a-f show<br>tiffed at  | ctor                | 10a. State 10b. County  MD Anne Arr   |   | y, Town or Lo  | cation  |  |  |  | 10d. Inside City Lim 1 ☐ Yes 2X   |
| 3a or 28   | I Dire              | 10e. Street and Number 4749 E. Flanders   | s I.ane   |  | 10f. Zip Code 20776                             |  | 1  | 0g. Citizen of Wha   | at Country?   |
| if, or itams 2<br>raminer mu   | by Funeral Director | 11. Marital Status  XXNever Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent Ever in U. Armed Forces?  1  Yes ZYNo If Yes, Give Year or Dates:  |  |   | ispanic Origin? (Spe<br>n, Mexican, Puerto f<br>Specify: | cify Yes or No-<br>Rican, etc.)  | 14. Race -<br>Black, 1   | American Indian,<br>White, etc.<br>White  |
| r than "natural", or itams 23a or 28a-f show<br>the Medical Examinat must be notified at | Completed           | 15. Decedent's E. (Specify only highest graves of the secondary (0-12) 1 1  | ducation<br>ade completed)<br>College (1-4or 5+)  | (Give<br>life. L                                       |   | ation<br>during most of workir<br>l)                     | ng   | 16b. Kind of Busin   | •   |
| kad othe<br>ic event,  | To Be Co            | 17. Father's Name (First, Middle, Last,   | )<br>11iams   | Elect  | rician  | 18. Mother's Name Patty E.                               |  | Maiden Sumame)   |   |
| item 27 ie mar<br>other traumat  | ľ                   | 19a. Informant's Name/Relationship ( James M. Williams  | s (Father)  | 4749   | Flanders  | Lane, Ha   | rwood, 1   | •  | ite, Zip Code)  |
| Important: If Item<br>any injury or othe<br>once.  |                     | 20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif.  21. Signature of Funeral Service Lice   | Removal from State (y) Lal  | emetery, cren  | sition (Name of natory or other place) Mem. Gdn | θ)   |  | 20c. Location - Cit<br>Davidsons   | y or Town, State  |
| ysicien and miner burial-transit be burial-transit unin                                  | ical Examiner       | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leauning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence)   uence of):<br>uence of):                               | one Intox                                       | ication  |  |  | Interval Between<br>Onset and Death   |
| attending pt<br>for use as t   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown                            | Ideath 3   | Ectopic pregnancy Other (specify)               |  |  | 23d. Date o<br>Month   | f delivery<br>Day Year  |
| cha th   | by Pt               | Part II. Other significant conditions of  | ontributing to death but not resi   | ulting in the ur                                       | nderlying cause give                            | en in Part I.  |  |  | te to the cause of death?   |
| en signed by the could be detached   | ed b                |   |   |  |   |  |  |  |   |
| ete hes been sign<br>pege 2 should be  | Completed           |   |   |  |   |  | 24a. Was ar<br>autops<br>perform<br>1 X Yes 2  | y prior deal   | r to completion of cause of   |
| ils certificate has been sign<br>director, page 2 should be                              | o Be Completed      | 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No   | Hospital: 1 ☐ Inpatient 2 🗷   | -<br>ER/Outpatien                                      | t 3□ DOA Othe                                   | 26. Place of Death                                       | autops<br>perform<br>1 Yes 2<br>Check on v on  | y prio<br>ned? dea<br>P□No 1Д  | r to completion of cause o<br>th?<br>Yes 2□ No  |
| After this certificate hes been sign funeral director, page 2 should be                  | To Be Completed     | examiner?   | 28a. Date of Injury Fnd/Month, Day Year)  | 3:30 A   | 28c. Injury<br>Work<br>1 1                      | er: 4 Nursing Hom<br>rat 2<br>Yes 2 No                   | autops perform 1 Yes 2  Check on one 1   | y prior deal need? 12 No | Yes 2□ No   |
| this certificate has been sign<br>al director, pege 2 should be                          | o Be Completed      | examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending investigation 3  Suicide 4 Homicide 6 XCould not be determined   | ZBa. Date of Injury Fnd(Month, Day Year)  12-19-05  28e. Place of Injury - At he building, etc. (Specify                  | 2:8b Time of nd Injury 3:30 A pme, farm, strey sidence | 28c. Injury Work 1 1                            | ar: 4 □ Nursing Hom<br>r at 2<br>?? 2<br>Yes 2           | autops perform 1 Yes 2 Check on one 5 Reside 8d. Describe ho 8f. Location (Str. City or Town | prior deal need? I A need? I A need? I A need? I A need and Number of the need and need the need | r to completion of cause of the P Yes 2□ No  Specify)  unk  r Rural Route Number  r Landers L |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 3:23 P M Douglas A. Whitcher December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Edgewater Anne Arundel 3740 Parke Drive If Under 1 Year It Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3-10-1948 Birthplace (State or Foreign Country) **Funeral** Months **™** M 2□ F Yrs. Director 57 Washington, Dc 217-50-9662 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "netural", or items 23a or 28a-f ehow the Medical Examinar quat be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Edgewater Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21037 USA 3740 Parke Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1967–71 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Aviation Ordnance U.S. Navy years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Marilyn Murray Lawrence S. Whitcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i 3740 Parke Drive, Edgewater, MD 21037 Joanne E. Whitcher/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 Department of importent: If any injury or once. 12-12-05 Davidsonville, MD Lakemont Cemetery 21. Signature of Feneral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death inetactales Priysician /Medical Examiner elde Ca Sequentially flet or different any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physicien end s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical attending physic IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 ☐ Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Remipian 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 No Division of Vital : After this cartifical funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 | Inpatient | 2 | EP/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending s effer des. ral Director: Afte Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 753306 ar lin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2140 to Rd Ste 300 Annapolis 900 Besta 2010 32 Registrar's Signature 31. Date filed (N State Registrar

|  |                     | 1 - For<br>State<br>Registrar   | State of Ma  | aryland                       |  | rtmen<br>tificat                   |                           |                                   | and M                    |                                       | giene<br>Reg. No.    | 005                           | 420                                    | 0 1                | 8               |
|--|---------------------|---|--|-------------------------------|--|------------------------------------|---------------------------|-----------------------------------|--------------------------|---------------------------------------|----------------------|-------------------------------|--|--------------------|-----------------|
| Physic   | ian                 | 1. Decedent's Name (First, Middle, Las<br>Nina May Wilson   | t)   |                               |  |                                    |                           |                                   |                          | 2. Date of De<br>Month<br>Decembe     |                      | 20 <b>0</b> 5°                | 3. Tim                                 | e of De            | ath<br>AM       |
| /Medi<br>Exami   |                     | 4a. Facility Name (If not institution, give   |  |                               |  |                                    |                           | Location o                        | of Death                 |                                       | 4c. C                | ntgome                        | ath                                    |                    | 11.             |
| Funeral<br>Director  |                     | 440-12-0000   | 7. Age   | e (In yrs. las                | t birthday).                                   | If Under<br>Months                 | 1 Year<br>Days            | If Under 2<br>Hours               |                          | 8. Date of Bir<br>(Month Da<br>Mar 23 | 191                  | 9. Bi                         | rthplace (Sta<br>Country)<br>Lahoma    | ate or Fo          | oreign          |
| ith the Maryland<br>or 28s-f show  | ctor                | Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome  | ery  |                               | Town or Longomery                              | y Vil                              |                           |                                   |                          |                                       |                      |                               |  | e City L<br>Yes 23 |                 |
| with the   | Dire                | 10e. Street and Number<br>19310 Club House  | Pood   |                               |  | 10f. Zip                           | Code<br>0886              |                                   |                          |                                       |                      | en of What C<br>ted St        | -                                      |                    |                 |
| permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Important: If Item 27 Ie marked other then "natural", or Items 23a or 28s-f ehow eny Injury erzether traumatic event, the Medical Examination to insufficient and once.   | by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent B<br>Armed Forces?<br>1 ☐ Yes 2 🛱 N<br>If Yes, Give<br>Year or Dates: |                               | 1  |                                    | lent of His<br>offy Cubar | spanic Orion, Mexican<br>Specify: | gin? (Spe<br>i, Puerto F | cify Yes or No<br>Rican, etc.)        | - 14                 | 4. Race - Am<br>Black, Wh     | nencan Indian                          | n,                 |                 |
| d within 72 h<br>giene.<br>er then "natu   | Completed           | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>12   | ucation<br>de completed)<br>College (1-4or 5   | +)                            | 16a. Deced<br>(Give<br>life. L<br>Secret       | kind of wo<br>OO NOT us            | rk done d                 | urina most                        | t of workin              | ng                                    | Fede                 | d of Busines<br>ral<br>rnment | -                                      |                    |                 |
| y lance out be file Mentel Hygarked otherstice event,  | To Be C             | 17. Father's Name (First, Middle, Last) Cecil Mounger   |  |                               |  |                                    |                           |                                   |                          | (First, Middle,<br>Heathe             |                      | Sumame)                       |  |                    |                 |
| d 2 sho<br>d 2 sho<br>th and<br>th and<br>traum  |                     | 19a. Informant's Name/Relationship (7) Stephen Wilson/ S  |  |                               |  | -                                  |                           |                                   |                          | Route Numbersl                        |                      |                               |  |                    |                 |
| intimitation of the strength o |                     | 20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Specify  21. Signature of Fuperal Service Licen                                     | Removal from State   | Ft.                           | ce of Dispos<br>netery, crem<br>Linc<br>netery | sition (Nar<br>natory or o<br>Coln | ne of<br>ther place       | D                                 | ecem<br>20               | ber 8,                                | 20c. Loc             | ation - City o                | r Town, State                          |                    |                 |
| D ed d ed o  |                     | 1 X1/m /  | 1/4  |                               | 10   | Eas                                | t De                      | er Pa                             | rk D                     | rive, (                               | Gaith                |                               | g, MD                                  | 208                | 377             |
| Pnysician<br>/Medical<br>Examiner  |                     | 23a. rt1. In rt din ase, or composition ock, by earth it e. List only imment ause (Final disease or condition resulting in death)                           |  | e Cord                        | onary  |                                    |                           | , such as                         | cardiac oi               | r respiratory a                       | rrest,               |                               | Approxi<br>Interval<br>Onset a<br>4 ho | Betwee             | ath             |
| sate be executed physicien and the burial-transit  | icai Examiner       | Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a Due to (or as a d.  |                               |  |                                    |                           |                                   |                          |                                       |                      |                               |  |                    |                 |
| auth certifii<br>ettending a<br>for use es   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown               | 2 Fetal de                    | eath 3   | Ectopic pr                         |                           |                                   |                          |                                       | 23                   | 3d. Date of de<br>Month       | elivery<br>Day                         | Yea                | ır              |
| w requires that the dibean signed by the should be deteched  | by                  | Part II. Other significant conditions of  | ontributing to death bu  | ut not resulti                | ing in the ur                                  | nderlying c                        | ause give                 | n in Part I.                      |                          |                                       | obacco us<br>Yes 2 🗆 | e contribute                  | to the cause<br>Probably 4             |                    |                 |
| The law received here  | Completed           |   |  |                               |  |                                    |                           |                                   | <u> </u>                 | 24a. Was<br>autor<br>perfo<br>1 🗆 Yes | rmed?                | 24b. Were a prior to death?   |  | ngs ava<br>of caus | ulable<br>se of |
| sician<br>sertifi<br>rector  | o Be                | 25. Was case referred to medical examiner?  1  Yes 2 No   | Hospital:  | nt 2□EF                       | 2/0  |                                    | Othe                      |                                   |                          | Check only                            |                      |                               |  | -                  |                 |
| nding Phy<br>th.<br>r: After this<br>e funeral d   | II-                 | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injur<br>(Month, Day  | y 28                          | 8b. Time of<br>Injury                          |                                    | 8c. Injury<br>Work        | 4 140                             | 2                        | ne 5 Resi                             |                      |                               | өсіту)                                 |                    |                 |
| tal or Atte  | Certification:      | 3 Suicide 6 Could not by<br>4 Homicide determined   | 28e. Place of Injubuilding, etc  | ury - At home<br>c. (Specify) | e, farm, stre                                  | eet, factory                       | r, office                 |                                   | 2                        | 8f. Location (<br>City or To          |                      | Number or F                   | Rural Route I                          | Vumber             | r               |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2  | edicai              | (Check only 21 Medical Exam   | ysician: To the best on the basis of and manner sta                                    | examination                   | edge, death<br>n and/or inv                    | restigation                        | , in my op                | inion, deal                       | d place, a<br>th occurre | and due to the                        | date and p           | place, and du                 | e to the cau                           |                    |                 |
| 10   | M                   | 29b. Signature and title of certifier   |  |                               |  |                                    | D15                       | number<br>236                     |                          |                                       |                      | signed (Mor                   |  |                    |                 |
| ()   |                     | 30. Name and address of person who Carl I. Margolis   | , M.D., 11   | eath (Item 2<br>125 Ro        | 3a) (Type,<br>ockvi                            | Print)<br>11e P                    | ike,                      | #211                              | , Ro                     | ckville                               | e, MD                | 20852                         | 2                                      |                    |                 |
| St   | ate                 | 31. Date filed (Month, Day, Year)   |  | ar's Signatur                 | е  | de                                 |                           |                                   |                          |                                       |                      |                               |  |                    |                 |

|  |                    | 1 - For<br>State<br>Registrar  | State of   | Marylar                          |   |   | of Health and<br>of Death         | d Mental Hyg  | iene<br>eg. No.     | )5 L  | 2019  |
|--|--------------------|--|--|----------------------------------|---|---|-----------------------------------|---|---------------------|---|---|
| Physici<br>/Medic  |                    | Decedent's Name (First, Middle, La   | ·  | IN EUG                           | ENE WE                                      | TZEL  |                                   | 2. Date of Dear<br>Month<br>Decembe                   |                     | 2005  | 3. Time of Death 1:25 A M                               |
| Examir   |                    | 4a. Fecility Name (If not institution, given 9344 Rocky Ridge  |  | ber)                             |   |   | m, or Location of De              | ath   |                     | nty of Death<br>derick                                  |   |
| Funeral<br>Director  |                    | 5. Social Security Number 213-34-7055 6. S   | Sex<br>M 2□F   | 7. Age (In yrs.<br>69            | -,  | If Under 1 Y<br>Months D                                    | ear If Under 24 H<br>ays Hours M  |   | 1936                | 9. Birthp<br>Cour<br>Mary                               | lace (State or Foreign<br>Land                          |
| Maryland a-f show  | ctor               | Usuel Residence of Decedent  10a. State  10b. County  Maryland Freder  | ick  |                                  | ty, Town or Lo                              |   |                                   |   |                     | 1   | 0d. Inside City Limits 1 ☐ Yes 2√2 No                   |
| with the   | i Dire             | 10e. Street and Number<br>9344 Rocky Ridge   | . Road   |                                  |   | 10f. Zip Co   |                                   | 1   | _                   | of What Cour  | itry?   |
| portition of a line of the control o | by Funeral Directo | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Dece<br>Armed For<br>1 Yes<br>If Yes, Giv.<br>Year or Da | ces?<br>2'⊡ No<br>e              |   | Was Decedent<br>f Yes, specify                              |                                   | (Specify Yes or No-<br>erto Rican, etc.)              | 14. F               | Race - Americ<br>Black, White,<br>I cify: Whi           | etc.  |
| ithin 72 hours on "ithin 72 hours on "natural", on workers in the manufactural of the  | Completed          | 15. Decedent's E(Specify only highest gr<br>Elementary/Specondary (0-12)   | ducation   |                                  | (Give                                       | dent's Usual O<br>kind of work d<br>DO NOT use n<br>Painter | one during most of v<br>etired)   | working   | 16b. Kind of        | f Business/Ind  |   |
| d be filed w<br>antal Hygier<br>sed other ti   | Be                 | 17. Father's Name (First, Middle, Last<br>Ezra David Wetzel  | )  |                                  |   | rainter   | 18. Mother's N                    | lame (First, Middle, i                                | Paint<br>Maiden Sum |   |   |
| Mical yand 2 shoul alth and Me 27 is mark  | 2                  | 19a. Informant's Name/Relationship (Patsy A. Wetzel (  |  |                                  | 19b. Mailir<br>9344                         | ng Address (Si<br>Rocky .                                   | reet and Number or<br>Ridge . Roa | Rural Route Number                                    | ; City or Tov       | wn, State, Zip<br>, MD 2                                | Code)<br>L778   |
| ages 1 a<br>int of Hea<br>t: If item<br>7 or othe  |                    | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐  |  | State                            | Place of Dispo<br>cemetery, crer<br>sthave: | natory or other   | of<br>Polace)<br>Gardens 1        |   |                     | on - City or To   | wn, State<br>Maryland                                   |
| Daltillo<br>permit. Pages<br>Depertment of<br>Important: If i<br>any injury or o   |                    | *4 □ Donation 5 □ Other (Speci<br>21. Signature of Funeral Service Lice  |  | 1 0                              |   |   |                                   | & SON, FUN  |                     |   |   |
| Physician<br>/Medical  |                    | 23a. Part1. Enter the disease or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)                     | one cause on   | red or de ch line.               | h. Do not ent                               | 15 EAST   | MAIN STR<br>dying, such as card   | EET, THUR   | MONT,               | MD 21   | Approximate Interval Between Onset and Death  6 — on 74 |
| cate be executed physician and the burial-transit  | dical Examiner     | Sequentially list conditions, if any, learn y to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c  | or as a consec                   |   |   |                                   |   |                     |   | ····  |
| death certifi<br>death certifi<br>e attending<br>od for use as   | Physician/Medi     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |  | rth 2 ☐ Feta<br>ant at time of o | al death 3                                  | ]Ectopic pregr<br>] Other (s <i>pecit</i>                   |                                   |   |                     | Date of delive  | ry<br>Day Year  |
| law requires that the as been signed by the 2 should be detache  | b                  | Part II. Other significant conditions  | contributing to de   | ath but not res                  | sulting in the u                            | nderlying caus  | e given in Part I.                |   |                     |   | ne cause of death?                                      |
| n a a  | Completed          |  |  |                                  |   |   |                                   | 24a. Was a<br>autops<br>perforr<br>1 \( \text{Yes} \) | y                   | b. Were auto<br>prior to cor<br>death?<br>1 \( \sum Yes | osy findings available npletion of cause of             |
| ysician:  <br>ysician:  <br>is certifice <br>director, p   | To Be              | 25. Was case referred to medical examiner?  1 Yes 2 Nio  | Hospital:  | npatient 2                       | ER/Outpatier                                | nt 3 DOA  |                                   | Death (Check only on<br>Home Reside                   |                     | Other (Specifi  | ()  |
| To the Hospital or Attending Physician: The twithin 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.  |                    | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | n  | of Injury<br>h, <i>Day Year)</i> | 28b. Time or<br>Injury                      | 28c.  | Injury at<br>Work?<br>1  Yes 2 No | 28d. Describe ho                                      |                     |   | ,   |
| ital or Attending urs after death. rai Director: After lied in by the fune   | Certification:     | 3 Suicide 6 Could not to determined  | 288. Place<br>buildir  | ig, etc. (Speci                  |   |   |                                   | 28f. Location (St<br>City or Town                     | n, State)           |   |   |
| the Hosp<br>hin 24 hou<br>tha Fune<br>npletely fil   | Medical            | (Check only 2 Medical Exa  | miner: On the ba   | isis of examina                  | ation and/or in                             | vestigation, in   | my opinion, death oc              | ace, and due to the cocurred at the time, d           | ate and plac        | e, and due to   | the cause(s)  |
| or viri  | -                  | 29b. Signature and title of certifier  30. Name and address of person who   **Cena Hudwd, W  31. Date filed (Month, Day, Year)  **DEC 13                   |  |                                  | . aus                                       | 296. 6  | cense number                      | 066   | PGCE V              | n ber   | 12, 200s  |
| '\r'   |                    | 30. Name and address of person who Kanan Hudhad, W   | ompleted cause   | of death (Ite                    | m 23a) (Туре.                               | Print)  | Drive,                            | Frederic  | K.                  | no o  | 21702   |
| Sta<br>Regist  | ate<br>rar         | 31. Date filed (Month, Day, Year) DEC 13   | 2005   | gistrar's Sign                   | ature A                                     | porte   |                                   |   |                     |   |   |

Amend item#26, perilly 6850, 12729/05 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Regi-No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician**  $12^{Month}$ Year Clyde Adams, Sr. 12:20 pM 2005 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A Johns Hopkins Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. 5, Social Security Number 6. Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**⋈** M 2□ F Months Hours 79 Director Yrs. 214-20-4470 Virginia Mar 18, 1926 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Madical Examiner must be notified at 1XTYes 2 No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Items 23a 2716 East Federal Street 21213 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No δ Specify: 3 ☐ Widowed 4 ☐ Divorced Black "naturat', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) American Smelting & Skilled Laborer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Menta! I ant: If itam 27 ia marked of Walter Adams Nannie Jones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessie Mae Adams Wife 2716 East Federal Street Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 12/30/05 Owings Mills, Md. ` 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician interct disease or condition My o cardia 3 weeks resulting in death) /Medical Due to (or as a consequence of) Examiner vears Tic stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Dav Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 ☐ Unknown δ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Bleed G I 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attanding Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Decidence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of ceptifier 29c. License number 29d. Date signed (Month, Day, Year) 1422 32 MS 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD ZIZZZ reeser 2112 Dundalk Ave. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

|                   |  |                     | 1 - For State Registrar  1. Decedent's Name (First, Middle, Last)  | State of Maryla   | -                                       | artment of H   |  | R  | g. No. U D                              | 42022   |
|-------------------|--|---------------------|--|---|---|--|--|--|---|---|
|                   | Physici<br>/Medio<br>Examir  | cal                 | Sor Ah A Ley (Lin)  4a. Facility Name (If not institution, give str  | reet and number)  |   | 4b. City, Town, or   | Location of Death                                    | 2. Date of Dea<br>Month<br>Decem           | Day Year                                | 5 0827AM  |
| 4.                | Funeral<br>Director  |                     | 5. Social Security Number 6. Sex   | v 2√7 F   | Center<br>rs. last birthday)<br>79 Yrs. | Bul 1<br>If Under 1 Year<br>Months Days                                  | If Under 24 Hrs. Hours Min.                          | 8. Date of Birth<br>(Month, Day<br>Jan 30, | year) 9. Bi                             | N/A  Inhplace (State or Foreign Country)  Maryland                    |
|                   | D  | tor                 | Usual Residence of Decedent  10a. State 10b. County  Maryland N/A  | 10c.  | City, Town or Lo                        |  | ltimore  | 341 30,                                    | 1320                                    | 10d. Inside City Limits 1X Yes 2 □ No                                 |
|                   | s or 28s   | i Direc             | 10e. Street and Number 1013 West Cross Street  |   |   | 10f. Zip Code  | 21230  | 1  | log. Citizen of What C                  | ,   |
| 980               | pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or Itams 23e or 28e-f show any injury or other traumatic svent, Ite Medical Excitor considerational and once. | by Funeral Director | 11. Marital Status 12 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced   | 2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:    |   | Was Decedent of Hi<br>If Yes, specify Cubai<br>1 ☐ Yes 2 🕱 No            | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>o Rican, etc.)        | 14. Race - Am<br>Black, Wh<br>Specify:  |   |
| 21215-0036        | i within 72 ho<br>jene.<br>r then "natur<br>I'e Medical  | Completed           | 15. Decedent's Educa<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   |   | (Give                                   | dent's Usual Occupa<br>kind of work done d<br>DO NOT use retired,<br>Hou | luring most of wor                                   | king                                       | 16b. Kind of Busines:                   | s/Industry Home   |
| Maryland 2        | should be filed<br>and Mental Hyg<br>marked othe<br>umatic svent,  | To Be C             | 17. Father's Name (First, Middle, Last) Rafeal F   | Rubie   |   |  | 18. Mother's Nam                                     |  | Maiden Sumame)<br>enne Rubie            |   |
|                   | and 2 sho<br>salth and I<br>n 27 ie me<br>er traume  |                     | 19a. Informant's Name/Relationship (Type<br>Carolyn Maxwell Daughter   | 9, Print)   | 1                                       | ng Address <i>(Street a</i><br>21 Uhler Aver                             |  |  | r, City or Town, State,<br><b>21215</b> | Zip Code)   |
| Baltimore,        | Pages 1:<br>nent of He<br>ant: if itan<br>ury or oth   |                     | 20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)   | I   |   | sition (Name of<br>natory or other place<br>us Memorial P                | +  | Date<br>12/30/05                           | 20c. Location - City o                  |   |
| Balt              | permit.<br>Deperti<br>Importi<br>anyinj  |                     | 21. Signature of fluneral Service Licensee   | Estel   | ) 22                                    | Name and Addres<br>Estep Bro<br>1300 Eut                                 | s of Facility<br>others Funer<br>taw Place Ba        | ral Service, F                             | P. A.<br>21217                          |   |
| E.                | Physician<br>/Medical<br>Examiner  |                     | 23a. Pan1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)               | ations that caused the dicause on each line.  Scasso Due to (or as a constitution)  | Shocy                                   | er the mode of dying   | g, such as cardiac                                   | or respiratory arr                         | est,                                    | Approximate Interval Between Onset and Death                          |
| 8760, 6           | The law requires that the death certificate be executed the has been signed by the ettending physician and tage 2 should be detached for use as the burial-transit   | dicai Examiner      | Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. | Due to (or as a cons  | sequ-nce of):                           | 100 6  |  |  |   | 11/22 - 12/20   |
| .O. Box 6         | the death certific<br>y the ettending p<br>ached for use as t  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♠ No 9 □ Unknown  | c. If yes, outcome of pre<br>1 Live birth 2 F<br>4 Pregnant at time of<br>9 Unknown | etal death 3                            | Ectopic pregnancy Other (specify)  |  |  | 23d. Date of de<br>Month                | elivery<br>Day Year   |
| rds, P            | w requires that the de-<br>been signed by the e<br>should be detached fi   | by                  | Part II. Other significant conditions control Congultive Heart Fo  |   | resulting in the u                      | nderlying cause give   | n in Part I.   |  | bacco use contribute e                  | to the cause of death?<br>Probably 4 Unknown                          |
| al Records,       |  | Completed           | Diabetes Mellitu<br>Peripheral Vascu   | u II<br>lar Diseas  | L                                       |  |  |  | med? death?<br>20 No 1 ☐ Ye             | utopsy findings available<br>completion of cause of<br>s 2 \square No |
| Division of Vital | ding P.<br>h.<br>After t   | ation: To Be        | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | spital: Inpatient 2<br>28a. Pate of Injury<br>(Month, Day Year                      | ER/Outpatier<br>28b. Time of<br>Injury  | 28c. Injury<br>Work  | <sup>IT:</sup> 4 ☐ Nursing H                         |  | ence 6 Other (Spa                       | ecify)  |
| Divis             | To the Hospital or Attentwithin 24 hours after deatl<br>To the Funerel Director:<br>completely filled in by the  | Certification:      | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - A<br>building, etc. (Spe                                     | ecify)                                  |  |  | City or Town                               |   |   |
|                   | To the Hosp<br>within 24 hou<br>To the Fune<br>completely fil  | Medicai             | one)   | cian: To the best of my or: On the basis of examinand manner stated.                | knowledge, death<br>iination and/or in  | vestigation, in my op  | inion, death occur                                   | rred at the time, d                        | ate and place, and du                   | e to the cause(s)   |
| •                 | To To  |                     | 29b. Signature and title of certifier  | Cellen  | MD                                      | 29c. License   | 891  | 6  | 9d. Date signed (Mon                    |   |
|                   | 11   |                     | 30. Name and address of person who com  Angula Di W  31. Date filed (Month, Day, Year)   | apleted cause of death (i   | 22 S                                    | outh G   | nene   | Street                                     | Balto                                   | MD 21201  |
|                   | Stá<br>Registr   |                     | DEC 2 9 2005   | Reserved It   | boorde                                  | ,  |  |  |   |   |

|                     |   | •                 | For<br>State<br>Ragistrar   | State of Ma  | ryland / D                | epartme<br>Certifica               | nt of H                      | lealth a<br>Death            | ind Me                     |                                      | iene<br>ig. No.            | )5 [                              | +202                     | 23             |
|---------------------|---|-------------------|---|--|---------------------------|------------------------------------|------------------------------|------------------------------|----------------------------|--------------------------------------|----------------------------|-----------------------------------|--------------------------|----------------|
| ,                   | Dhysioir  | 3.0               | 1. Decedent's Name (First, Middle, La   | _  |                           |                                    |                              |                              | 2                          | 2. Date of Death                     | Day                        | 2 XeeF                            | 3. Time o                |                |
|                     | Physicia<br>/Medic  |                   |   | derson   |                           | 11.00                              | . Taura at                   | l continu                    |                            | Decembe:                             | 7                          | 2005<br>inty of Death             | 8:50                     | Дм             |
|                     | Examin  | er                | 4a. Facility Name (If not institution, given 1001 Thompson Bou  |  |                           |                                    | sex                          | Location of                  | Death                      |                                      |                            | ltimor                            |                          |                |
|                     | Funeral   |                   | 5. Social Security Number 6. S  | ex 7. Age  | (In yrs. last birti       | nday) If Und<br>Month              | er 1 Year<br>Days            | If Under 2                   | 24 Hrs. 8                  | B. Date of Birth<br>(Month, Day,     | Year)                      | 9. Birth                          | place (State ontry)      | or Foreign     |
|                     | Director  |                   | 218-54-0833 Usual Residence of Decedent   | <b>Ç</b> M 2□F   | 57                        | Yrs.                               | 20,0                         |                              |                            | Dec. 3,                              | 1948                       | Mary                              | land                     |                |
|                     | /land   |                   | 10a. State 10b. County  |  | 10c. City, Town           | or Location                        |                              |                              |                            |                                      |                            |                                   | 10d. Inside C            | ity Limits     |
|                     | a-f eh  | ctor              | Maryland Baltimo  | re   | Essex                     | K .                                |                              |                              |                            |                                      |                            |                                   | 1 🗌 Yes                  | 2 <b>XX</b> 0  |
|                     | vith the  | Funeral Director  | 10e. Street and Number  |  |                           |                                    | Cip Code                     |                              |                            | 10                                   |                            | of What Cou                       | intry?                   |                |
|                     | eath v  | eral              | 1001 Thompson Bou   | 12. Was Decedent 8   | ver in U.S.               |                                    | 21221<br>edent of Hi         |                              | oin? (Speci                | ifv Yes or No-                       |                            | .S.A.                             | ican Indian,             |                |
| 36                  | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 ie merked other then "natural", or Itame 23e or 28e-f ehow or other traumatic avent, the Medical Examinar must be multified at | by Fun            | 1 Never Married 2 Married 3 Widowed 4 Divorced  | Armed Forces?  1XDYes 2 □ N If Yes, Give Year or Dates:        | 1968_                     |                                    | ecify Cuba                   | n, Mexican, Specify:         | , Puerto Ri                | ify Yes or No-<br>ican, etc.)        |                            | Black, White<br>e <i>cify:</i> Wh | ite                      |                |
| Maryland 21215-0036 | r2 hou  | ted               | 15. Decedent's Ed<br>(Specify only highest gra  | ducation   | 16a.                      | Decedent's Us<br>(Give kind of the |                              |                              | of working                 | 7                                    | 16b. Kind o                | l Business/Ir                     | ndustry                  |                |
| 21                  | within 7<br>ene.<br>than "r   | Completed         | Elementary/Secondary (0-12)   | College (1-4or 5   | +)                        | life. DO NOT                       | use retired                  | 1)                           | or working                 | <b>'</b>                             | The out                    |                                   | _                        |                |
| d 21                | filed w<br>Hygiel<br>ther th  | e Co              | 17. Father's Name (First, Middle, Last,   | 5+   | C1\                       | vil Eng                            | meer                         |                              | r's Name (                 | First, Middle, A                     |                            | neerin<br>name)                   | ıg                       |                |
| lan                 | Mental Mental arked o   | To Be             | John Joseph Ander   |  |                           |                                    |                              |                              |                            | Rue Gri:                             |                            |                                   |                          |                |
| lary                | 2 should be and Mental le marked (aumatic av  | -                 | 19a. Informant's Name/Relationship (  | **   | - 1                       | -                                  |                              |                              |                            | Route Number,                        |                            |                                   |                          |                |
|                     | is 1 and 2<br>of Health a<br>item 27 le   |                   | Saundra Anderson  | (Wife)   | 1 (<br>20b. Place of      | ***                                | -                            | Boul                         | evaro.                     | d, Balt                              |                            | , Mary<br>on-City or T            |                          | 21221          |
| nor                 | nt of h   |                   | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  |  | cemeter                   | y, crematory o                     | r other plac                 |                              |                            | ,2005 B                              |                            | •                                 |                          | nd             |
| Baltimore,          | permit. Pages<br>Department of I<br>Important: If ite<br>any injury or o'   |                   | 4 □Donation 5 □Other (Special 21. Signature of Funeral Pervice Lice   |  | HOLLY                     | 22. Name                           | and Addres                   | ss of Facility               | y                          |                                      |                            |                                   |                          |                |
| ш                   | <u>v</u> ∪ ≥ € 0  | 2                 | 23a. Part1. Enter the disease, or com   | plications that caused   | the death. Do n           |                                    |                              |                              |                            | Funera<br>venue,                     |                            | , Mary                            | land 2                   |                |
| 1                   | 8   |                   | shock, or heart failure. List only<br>Immediate Gause (Final  | one cause on each lin  | Θ.                        |                                    |                              |                              |                            | ,,                                   |                            |                                   | Onset and                | tween<br>Death |
|                     | Pnysician<br>/Medical   |                   | disease or continuon resulting in death)  | a.   | 7AT/C<br>a consequence of | COLO                               | 10 6                         | HIVE                         | LK_                        |                                      |                            |                                   | L MOI                    | V1173          |
| 7                   | Examiner  |                   | Sequentially list conditions,   | b. Acute   |                           |                                    | lure                         |                              |                            |                                      |                            |                                   | 1 moi                    | TH             |
|                     | led<br>sit  | nine              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a  | a consequence of          | ol):                               |                              |                              |                            |                                      |                            |                                   |                          |                |
| Ć,                  | sicien and<br>burial-transit  | Examine           | that initiated events<br>resulting in death) Last   | C<br>Due to (or as a   | a consequence of          | ol):                               |                              |                              |                            |                                      |                            |                                   |                          |                |
| 8760,               | cate be executed<br>physicien and<br>the burial-transit   |                   | (   | d  |                           |                                    |                              |                              |                            |                                      |                            |                                   |                          |                |
| 9                   | eath certifica<br>attending pt<br>I for use as ti   | Physician/Medical | IF FEMALE:  | 23c. If yes, outcome   | of arageneous             |                                    |                              |                              |                            |                                      |                            |                                   |                          |                |
| Вох                 | death certific<br>e attending p<br>od for use as 1  | clan              | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth 4 Pregnant at                                     | 2 Fetal death             | 3 □Ectopic<br>5 □ Other            |                              | ,                            |                            |                                      | 230.                       | Date of delive                    | •                        | Year           |
| 0                   | by the destached  | hysi              | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknown   |                           |                                    |                              |                              |                            |                                      |                            |                                   |                          |                |
| Vital Records, P.   | es the  | Ď                 | Part II. Other significant conditions   | contributing to death bu                                       | ut not resulting in       | the underlying                     | g cause give                 | en in Part I.                |                            | 1                                    | acco use o                 |                                   | the cause of             |                |
| 900                 | law requir<br>es been si<br>2 should  | ompleted          |   |  |                           |                                    |                              |                              |                            | 24a. Was a autops                    | n 2                        | 4b. Were aut                      | opsy findings            | available      |
| E E                 | The<br>ate h<br>page  | Com               |   |  |                           |                                    |                              |                              |                            | perforr                              |                            | death?<br>1 ☐ Yes                 | 2 No                     |                |
| Vita                | Physician: Th<br>this certiticate<br>ral director, pag  | Be                | 25. Was case relerred to medical examiner?  | Hospital:  |                           |                                    | Oth                          | 00                           |                            | (Check only on                       |                            |                                   |                          |                |
| of                  | Phys<br>er this<br>eral di  | ): To             | 1 Yes 2 No  27. Manner of Death   | 28a. Date of Injur   | y 28b. T                  | Time of                            | 28c. Injun<br>Worl           | 4 🗆 1401                     | rsing Hom<br>28            | e 5/2/Reside<br>3d. Describe ho      |                            | Other (Spec                       | ify)                     |                |
| ion                 | Attending in death.   | atlo              | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   |  | / Year) II                | njury<br>M                         |                              | k?<br>Yes 2 □f               | No                         |                                      |                            |                                   |                          |                |
| Division            | = = = =   | Certification:    | 3 Suicide 6 Could not be determined   |  |                           | rm, street, lact                   | ory, office                  |                              | 28                         | BI. Location (St<br>City or Town     |                            | umber or Rui                      | ral Route Nur            | nber,          |
|                     | To the Hospitel of within 24 hours af To the Funeral D completely tilled in   | Medical C         | 29a. Certifier Check only one) Certifying Pl  | nysician: To the best of miner: On the basis of and manner sta | examination an            | dor investigati                    | ed at the tin<br>on, in my o | ne, date and<br>pinion, deat | d place, ar<br>th occurred | nd due to the ca<br>d at the time, d | ause(s) and<br>ate and pla | d manner as<br>ce, and due        | stated.<br>to the cause( | s)             |
|                     | To th<br>within<br>To th<br>compl   | Me                | 29b. Signature and title of certifier   | 2  | /                         | 1 -                                | 9c. Licensi                  |                              |                            |                                      |                            | gned (Month                       |                          |                |
| •                   | V   |                   | Marchan (12   | unfuch   | MD                        |                                    | D33                          | 551                          |                            | 1                                    | ec.                        | 29,                               | 2005                     | 7              |
|                     | 13  |                   | 30. Name and address of person who MICHREL AUERBA   | completed cause of d   | Philopple                 | (Type, Print)                      | 0 #                          | 314,                         | BN                         | Himes                                | e                          | 2123                              | 37                       |                |
|                     | Sta<br>Registi  |                   | 31. Date lited (Ments) Day, Year 5  | 32. Registra   | ar't Signatur             | all!                               |                              |                              |                            |                                      |                            |                                   |                          |                |

|                            |   |                   | 1 - For<br>State<br>Registrar  | State of Maryla   |                                     |                        |  | lealth ai<br>Death            | nd Mer                   |   | iene<br>g. No. 005                     | 5 420                                     | 24                                    |
|----------------------------|---|-------------------|--|---|-------------------------------------|------------------------|--|-------------------------------|--------------------------|---|--|---|---------------------------------------|
| ×.                         | Physici   | an                | 1. Decedent's Name (First, Middle, Las   | BYNTIN C  |                                     |                        |  |                               | 2.                       | Date of Deat<br>Month                   | Day Y                                  | 3. Time o                                 |                                       |
|                            | /Medic  |                   | An Equilibration of the particular of the  | atroat and number)  |                                     | 4b. Cit                | , Town, or                               | Location of                   | Death                    | 12                                      | 21 26<br>4c. County of                 | ) 63                                      | I.M.                                  |
| 1                          | Lxamii  | ்.                | Howard (   | ouly Gener  | 1 Hospit                            | ul                     | -  | vumb                          |                          |   | How                                    |   |                                       |
|                            | Funeral<br>Director   |                   | 5. Social Security Number 6. St 431–40–5188  Usual Residence of Decedent   | 7. Age (In y  | rs. last birthday,<br>Yrs.          | If Und<br>Months       | er 1 Year<br>Days                        | If Under 24<br>Hours          | 4 Hrs. 8.<br>Min. 1      | Date of Birth<br>(Month, Day,<br>0/12/1 | Year) 9.<br>927 .                      | Birthplace (State<br>Country)<br>Arkansas | or Foreign                            |
|                            | 72 hours after death with the Maryland<br>netural', or Iteme 23a or 28a-f ehow<br>jircal Examiner must be maillied at                                 |                   | 10a. State 10b. County   | 10c.  | City, Town or L                     | ocation                |  |                               |                          |   |  | 10d. fnside C                             | ity Limits                            |
|                            | Ba-f s  | ctor              | NJ Ocean   | La  | kewood                              |                        |  |                               |                          |   |  | 1 ☐ Yes                                   | 2XXN0                                 |
|                            | with the  | Funeral Director  | 10e. Street and Number<br>137 E. Kennedy B1  | · d   |                                     |                        | ip Code                                  |                               |                          |   | 0g. Citizen of Wha                     | at Country?                               |                                       |
|                            | death<br>ms 23  | era               | 11. Marital Status   | 12. Was Decedent Ever in  | U.S. 13.                            | Was Dec                | 701<br>edent of H                        | ispanic Origi                 | in? (Specify             | v Yes or No-                            | SA 14. Race -                          | American Indian,                          |                                       |
| 9                          | or Its  | Fur               | 1 Never Married 2 Married  | Armed Forces?  17 Yes 2 No 17 Yes, Give   |                                     | If Yes, sp<br>1 ☐ Yes  |  | Specify:                      | Puerto Ric               | an, etc.)                               |  | White, etc.                               |                                       |
| 8                          | hours<br>lural',  | ed by             | 3 ☐ Widowed 4\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\  | Year or Dates: Kor  | ean                                 |                        | 71.71                                    |                               |                          |   | Specify:                               |   |                                       |
| 21215-0036                 | a within 72 hours after death with the Marylan<br>Jiene.<br>r then "neturel", or items 23a or 28a-f show<br>The Madical Extending mast be notified at | Completed         | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | Coltege (1-4or 5+)  | (Give                               | kind of w              | ual Occupa<br>rork done d<br>use retired | during most o                 | of working               |   | 16b. Kind of Busin                     | iess/industry                             |                                       |
| 212                        | filed within<br>Hygiene.<br>Nhar then on<br>the Mac   | Com               | 12   | 4   | Elect                               | ricia                  | an ,                                     |                               |                          |   | U.S. Gov                               | vernment                                  |                                       |
| Maryland                   | _ 0 9   | Be                | 17. Father's Name (First, Middle, Last)  | _   |                                     |                        |  | 18. Mother                    | 's Name (F               | irst, Middle, A                         | Maiden Sumame)                         |   |                                       |
| 7                          | 2 should be<br>and Menta<br>is marked<br>aumatic ev   | 2                 | Benjamin Harrison  19a. Informant's Name/Relationship (1)  |   | 19b Maili                           | ng Addro               |  | Susie                         |                          |   | City or Town, Sta                      | 7:- O- d-1                                |                                       |
|                            | nd 2 s<br>lith an<br>27 is<br>r trau  |                   | Patricia Ann Smith   |   | 8698                                | - 99                   |  |                               |                          | 45 45                                   |  | , _, _,                                   |                                       |
| altimore,                  | es 1 an<br>of Heal<br>of Itam 2<br>r other  |                   | 20a. Method of Disposition   | 201   | . Place of Disponentery, cre        | osition (Na            | ame of                                   |                               | Date                     | Limb La.                                | MD 2104<br>20c. Location - Cit         | y or Town, State                          |                                       |
| ΪΞ                         | ment<br>ment<br>ment: h   |                   | 1 ☐ Burial <b>2√</b> Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify  | ) M   | etro Cr                             |                        |  | 12                            | 2/27/2                   | 2005                                    | Catonsvil                              | le, MD                                    |                                       |
| Ball                       | permit. Pages Department of H<br>Important: If Its<br>any Injury or of  |                   | 21. Signature of Funeral Service Licen   | S00   |                                     |                        |  | ss of Facility                | Witz                     | zke Fur                                 | neral Hom                              | es, Inc.                                  |                                       |
| 1 10                       |   |                   | 23a. Part1. Enter the disease, or com  | ofications that caused the de   |                                     |                        |  | Knolls                        |                          |   | olumbia,                               | MD 21045                                  | te                                    |
|                            | Physician<br>/Medical<br>Examiner   |                   | Immediate Cause (Final disease or condition resulting in death)  | aDue to (or as a cons   | equence of):                        |                        |  | meer                          |                          |   |  | fnterval Be<br>Onset and                  |                                       |
| p                          | ecuted<br>and<br>-transit   | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a cons   |                                     |                        |  |                               |                          |   |  | 1   | · · · · · · · · · · · · · · · · · · · |
| 8760,                      | cate be executed<br>physicien and<br>s the burial-transit   |                   | (  | d   | equence or,                         |                        |  |                               |                          |   |  |   |                                       |
| P.O. Box 6                 | that the death certificate be executed ted by the attending physicien and detached for use as the burial-transit                                      | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of pred<br>1 ☐ Live birth 2 ☐ Fi<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | etal death 3                        | ⊒Ectopic<br>⊒ Other (s | pregnancy<br>specify)                    |                               |                          |   | 23d. Date o<br>Month                   |   | Year                                  |
| rds, P                     | law requires that the<br>as been signed by th<br>2 should be detache  | þ                 | Part II. Dther significant conditions of   | ontributing to death but not i  | esulting in the u                   | ınderlying             | cause give                               | en in Part I.                 |                          |   |  | te to the cause of o                      | _                                     |
| Reco                       | φ <u>-</u> <u>0</u>   | Completed         |  |   |                                     |                        |  |                               |                          | 24a. Was ar<br>autops<br>perform        | ned? prior deal                        |   | available<br>ause of                  |
| ita                        | ysician: Th   | Be C              | 25. Was case referred to medicat   |   |                                     |                        |  | 26. Ptace o                   | of Death (C              | 1 ☐ Yes 2<br>Theck only one             |  | Yes 2□No                                  |                                       |
| of V                       | × 5 0   | ၉                 | 1 193 2 2 100  | Hospital: 1 Inpatient 2   |                                     |                        |  | 4 LI Nurs                     | sing Home                | 5 🗆 Reside                              | nce 6 🗆 Other (                        | Specity)                                  |                                       |
| uc                         | Jing P  | lon:              | 27. Manner of Death 1 ☑Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of fnitury                | of<br>M                | 28c. fnjury<br>Work                      | /at<br>k?<br>Yes 2⊟No         | i                        | . Describe ho                           | w injury occurred                      |   |                                       |
| Division of Vital Records, | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral           | Certification:    | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  |   | t home, farm, st                    |                        |  | 19S 2   NO                    |                          | Location (Str<br>City or Town           |  | or Rural Route Num                        | nber,                                 |
|                            | To the Hospital of within 24 hours at To the Funeral D completely filled in   | Medical C         | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam  | ysician: To the best of my kiner: On the basis of exam and manner stated.                       | nowledge, deat<br>ination and/or in | h occurre              | d at the tim                             | ne, date and<br>pinion, death | place, and<br>occurred a | due to the ca<br>at the time, da        | use(s) and manne<br>ite and place, and | or as stated.<br>due to the cause(s       | 5)                                    |
|                            | To the within To the comp   | Me                | 29b. Signature and title of certifier  |   |                                     |                        | 9c. License                              |                               |                          |   | d. Date signed (A                      | 1   |                                       |
|                            |   |                   |  | MD  |                                     |                        | 1)0                                      | 0537                          | 07                       |   | 12/23                                  | 3/2000                                    |                                       |
|                            | 10  |                   | 30. Name and address of person who   |   | tem 23a) (Type,                     | Print)                 | ont-                                     | Fox                           | <i>Sar</i>               | n S                                     | TE 21                                  | o Bowi                                    | e                                     |
|                            | Sta<br>Registr  |                   | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signary   | nature                              |                        |  |                               |                          |   | me                                     | 2/03                                      | 7                                     |

|             |  |                  | ricase  | •   |  | at at Usalta and  | -  |                            | Legible.                        |   |
|-------------|--|------------------|---|---|--|---|--|----------------------------|---------------------------------|---|
|             |  |                  | for State   | State of Marylan  |  |   | Mental Hy                                | /giene                     | 105                             | 12025   |
| -           |  |                  | Registrar   |   | Centitica  | ite of Death  |  | Reg. No.                   | 000                             | TEULU   |
|             | Physici  | an               | Decedent's Name (First, Middle, La  |   |  |   | 2. Date of D<br>Month                    | eath<br>Day                |                                 | 3. Time of Death                                    |
|             | /Medio   |                  | tennel T.   | Bention   |  |   | pec                                      | 21                         | 2005                            | 1534 M  |
|             | Examir   | er               | 4a. Facility Name (If not institution, give   | 1 1 1 1   | 4b. Ci   | y, Town, or Location of Dea                                   |  | 4c.                        | County of Dea                   | th  |
| 3.1         | 1  |                  |   | ryland Med. C   | enter B  | altimore, 1   |  |                            |                                 |   |
|             | Funeral  | 1                | 5. Social Security Number 6. S  | Gex 7. Age (In yrs.   | Yrs. Month   |   |  | ay, Year)                  | 7 9. Bir                        | thplace (State or Foreign quntry)                   |
| 14          | Director   | 0                | Usual Residence of Decedent   | 5   | 7  |   | 2 4                                      | - /                        | DIN                             | Carofila  |
|             | land<br>ow   |                  | 10a. State 10b. County  | 10c. Cit  | y, Town or Location                                |   |  |                            |                                 | 10d. Inside City Limits                             |
|             | with the Maryland<br>a or 28a-f show   | tor              | MD  | $\mathcal{A}$   | altim  | one 2   |  |                            |                                 | 1 No 2 No   |
|             | r 28a  | Funeral Director | 10e. Street and Number  |   | 101.2  | Zip Code  |  | 10g. Citi                  | zen of What C                   | ountry?   |
|             | 3a o   | Q                | 1131 N. Car   | eg Stroo-   | <i>f</i>   | 21217   |  | 1                          | 15A                             |   |
|             | death  | Jer              | 11. Marital Status  | 12. Was Decedent Ever in U                                    | .S. 13. Was Dec                                    | cedent of Hispanic Origin? (<br>Decify Cuban, Mexican, Pue    | Specify Yes or N                         | 0-                         | 14. Race - Ami                  |   |
| 9           | after or Its   | Ē                | Never Married 2 Married   | Armed Forces?  1  Yes 2 No                                    |  |   | irto Hican, etc.)                        | }                          | Black, Whi                      | te, etc.  |
| 5-0036      | hours after<br>tural', or ite  | by               | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                                | 1 Yes  | 21 No Specify:  |  |                            | Specify: B                      | ach   |
| 5-0         | natu   | Completed        | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)                                    | 16a. Decedent's U                                  | sual Occupation<br>work done during most of w                 | orkina                                   | 16b. Kir                   | nd of Business                  | Vindustry   |
| 7           | within<br>ene.<br>then   | ldu              | Elementary/Secondary (0-12)   | College (1-4or 5+)  | life. DO NOT                                       |   | ,  | 11                         | 1                               | - 1   |
| 21          | e filed within all Hygiene. I other than "   | Co               |   |   | Las  | orer  |  | HO                         | Me 1                            | y provenent   |
| pu          | be fill H d oth  | Be               | 17. Father's Name (First, Middle, Last  | )   |  | 18. Mother's N  | ame (First, Middle                       | e, Maiden                  | Sumame)                         | 1.  |
| yla         | ould<br>Men<br>Parke   | <sup>2</sup>     | Crady Iron  | ras   |  | Rus   | hie/                                     | Mae                        | Ber                             | stion   |
| Maryland    | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Midrial Exercities could be collified at   |                  | 19a. Informant's Name/Relationship  | Type, P(int) Dung Like  | 9b. Mailing Addre                                  | ss (Street and Number or I                                    | Rural Route Numi                         | ber, City or               | Town, State,                    | Zip Code)   |
| -           | of Health<br>of Health<br>Itam 27 I  |                  | jersaj.co   | rter  | Place of Disposition (A                            | THOUNT  | G. B                                     | alt                        | DMD -                           | 21216   |
| altimore    | if ital  |                  | 20a. Method of Disposition 1 ☐ Burial 2 Disposition 3 [   |   | emetery, crematory o                               | ame of<br>r other place)                                      | Date                                     | 20c. Lo                    | cation - City or                | Town, State   |
| Ë           | permit. Page<br>Department of<br>mportant; If<br>any Injury or<br>ance.  |                  | 4 □ Donation 5 □ Other (Special   | (y)   | RENMOUN  | H rematory  | 12/31/0                                  | 5 Ja                       | 10.                             | MO  |
| Ball        | Deparition Departiment Important Information Informati |                  | 21. Signature of Funeral Service Lice   | nsee  | 22.Name  | and Address of Facility                                       | Frener                                   | al S                       | eruic                           | 25  |
| ш           | ₹0 = 9   |                  | Jord N. D.  | in the their  | 119-   | 1215 Stric  | KerSt                                    | ·Bal                       | Cto Mi                          | 21223   |
| ю           |  |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | cations that caused the deat<br>one cause on each line.       | h. Do not enter the m                              | ode of dying, such as cardi                                   | ac or respiratory                        | arrest,                    |                                 | Approximate<br>Interval Between                     |
|             | Physician  |                  | Immediate Cause (Pinal disease or condition   | Multional   | n Sustan   | n failure   |  |                            |                                 | Onset and Death                                     |
|             | /Medical   |                  | resulting in death)   | Due to (or as a conseq  | uence of):   | 7 (7/01/  |  |                            |                                 | 7 - 7 -   |
| ю           | Examiner   |                  | Sequentially list conditions.   | b. Septic 5   | NOCK   |   |  |                            |                                 | 5 Day S   |
| 1           | P #  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due/to (or as a conseq  | ruence of):  |   |  |                            |                                 | 2   |
| ×           | and<br>trans   | am               | that initiated events resulting in death) Last  | 0   | ecus aur   | eus intect  | 100                                      |                            |                                 | 2 weeks   |
| 760,        | that the death certificate be executed<br>ed by the attending physician and<br>detached for use as the burial-transit  |                  | rosuming in usual) cast   | Due to (or as a conseq  | luence of):  |   |  |                            |                                 |   |
| 87          | hysin  | dical            | •   | d   |  |   |  |                            |                                 |   |
| x 68        | certifica<br>nding ph  | by Physician/Med | IF FEMALE:  | 00-16   |  |   |  |                            |                                 |   |
| Вох         | ath c  | lan              | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta     | I death 3 □Ectopic                                 |   |  | 2                          | 3d. Date of de<br>Month         | livery<br>Day Year                                  |
| _           | requires that the death<br>een signed by the atter<br>nould be detached for L  | /sic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of d<br>9□Unknown                          | leath 5 ☐ Other                                    | specify)  |  |                            |                                 | ,   |
| P.O.        | hat the day  | P.               | Part II. Other significant conditions   | contributing to death but not ree                             | ulting in the underlying                           | cours green in Bart I   | 23e Did                                  | tobaccou                   | se contribute t                 | o the cause of death?                               |
| Records,    | iw requires that<br>s been signed b<br>should be deta  | by               | Tarrin, Other significant contactors  | contributing to death but not res                             | alting in the underlying                           | Cause given in Pair i.  |  |                            | No 3□P                          |   |
| 9           |  | stec             |   |   |  |   | -  | 103 20                     |                                 | TODAD!  |
| jec         | alaw<br>hasb<br>e 2 sl   | Completed        |   |   |  |   | 24a. Wa<br>auto                          | ppsy                       | prior to                        | utopsy findings available<br>completion of cause of |
| <u>E</u>    | : The l  | Co               |   |   |  |   | 1 Yes                                    | ormed?<br>2 No             | death?                          | 2 □ No  |
| Vital       | Physician: The law<br>this certificate has t<br>ral director, page 2 s   | Be               | 25. Was case referred to medical examiner?  | (In-real)   |  |   | eath (Check only                         | one)                       |                                 |   |
| of          | > 0 0  | 2                | 1 ☐ Yes 2 ☑ No  |   | ER/Outpatient 3                                    |   | Home 5 Res                               |                            |                                 | ecify)  |
| Ē           | Jing P   | on:              | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)                      | 28b. Time of<br>Injury                             | 28c. Injury at<br>Work?                                       | 28d. Describe                            | how injury                 | occurred                        |   |
| sio         | Attending in death. ector: After by the fune   | catl             | 2 Accident investigation 3 Suicide 6 Could not be   |   | М  | 1 Yes 2 No  |  |                            |                                 |   |
| Division of | or At<br>fter d<br>Nrect<br>in by  | Certification:   | 4 Homicide determined   |   | ome, farm, street, fact<br>(y)                     | ory, office   | 28f. Location<br>City or To              | (Street and<br>own, State) | d Number or R                   | ural Route Number,                                  |
|             | Hospital or<br>4 hours afte<br>Funeral Dir<br>tely filled in   | ပိ               |   |   |  |   |  |                            |                                 |   |
|             | Hosp<br>24 ho<br>Fune<br>Fune<br>tely f  | lica             | (Check only 2 Medical Exa   | hysician: To the best of my knominer: On the basis of examina | owledge, death occurre<br>ation and/or investigati | ed at the time, date and place<br>on, in my opinion, death oc | ce, and due to the<br>curred at the time | cause(s)<br>, date and     | and manner as<br>place, and due | s stated.<br>e to the cause(s)                      |
|             | the<br>the   | Medical          | one) 29b. Signature app title of certifier  | and manner stated.  |  | 9c. License number  | 1  |                            | e signed (Mon                   |   |
|             | To To  |                  | 255. Signature and title of certifier   | 1   | 1  |   |  |                            |                                 |   |
|             | (  |                  | 1100  | MIT   |  | P18600  |  | VEC                        | C1 16                           | ,,,   |
|             | d  |                  | 30. Name and address of person who  | completed cause of death (Iter                                | n 23a) (Type, Print)                               | 21201   | f a.                                     | C.                         | 21, a                           | MA  |
|             | \  |                  | 31. Date filed (Month, Day Year) 2  | 22 Parisher S'  | more, MU   | cicul   | Je.                                      | lives                      | LIU                             | 1 1910  |
|             | Sta<br>Regist  |                  | 31. Date filed (Month, Day Ed.) 2   | 9 2005 Negitrars Signa  | H. Long  | de  |  | •                          |                                 |   |
| 100         | , in all of  | el .             |   | PROPERTY.   | -  | As and  |  |                            |                                 |   |

Amend item#5, periffi, of Mondon (Department of Health and Mandall Inc.

| Lar C     |   |                | 1 - State<br>Registrer   |                                       | of Márylar   |                                    |                       | nt of Healti<br>te of Dea                                     |                             |  | jiene<br>eg. No.                | 5 1                           | 2026  |
|-----------|---|----------------|--|---------------------------------------|--|------------------------------------|-----------------------|---|-----------------------------|--|---------------------------------|-------------------------------|---|
|           | Physici<br>/Medic   |                | Decedent's Name (First, Middle,  John Fost   |                                       | າ  |                                    |                       |   |                             | 2. Date of Dea<br>Month<br>December        | Day                             | 2005                          | 3. Time of Death<br>6:15 PM                         |
|           | Examin  | ier            | 4a. Facility Name (If not institution, Edenwald  | give street and nu                    | mber)  |                                    |                       | , Town, or Locati<br>OWSON                                    | on of Death                 |  |                                 | y of Death<br>1 <b>1tim</b> C | ore   |
|           | Funeral<br>Director   |                | 5. Social Security Number 715–93–7222  | S. Sex<br>M  M  2 □ F                 | 7. Age (In yrs.  | last birthday)<br>88 Yrs.          | If Unde<br>Months     |   | der 24 Hrs.<br>rs Min.      | 8. Date of Birth<br>(Month, Day<br>March 2 |                                 | 9. Birthp                     | lace (State or Foreign                              |
|           | show  | ٦c             | Usual Residence of Decedent  10a. State 10b. County  Manual 1 Delta:   |                                       | 10c. Cit   | ty, Town or Lo                     |                       |   |                             |  |                                 | 1                             | 0d. Inside City Limits 1 ☐ Yes 2√2 No               |
|           | death with the Maryland<br>me 23a or 28a-f show<br>rmust be natified at   | Directo        | Maryland Balti 10e. Street and Number  |                                       |  | Towsor                             | 10f. Z                | p Code  |                             |  | Og. Citizen of                  | What Cour                     |   |
|           |   | Funerai        | 800 Southerly R  | 12. Was Dec<br>Armed F                | edent Ever in U  | 16                                 | Vas Dec               | 21286<br>edent of Hispanic<br>ecify Cuban, Mex                | Origin? (Sp                 | pecify Yes or No-                          |                                 | ce - Americ                   |   |
| 2-0036    | "natural", or ite   | ρ              | 1 ☐ Never Married 2 🕅 Marrie<br>3 ☐ Widowed 4 ☐ Divorced   | If Yes, G<br>Year or I                | ive 19   | 45                                 |                       | 2 No Spec   | cify:                       |  | Specia                          | fy: Wh:                       | ite   |
| -61212    | within 7<br>ane.<br>then "n   | Completed      | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)   | grade completed,                      | 1-4or 5+)  | (Give                              | kind of w<br>OO NOT   | ual Occupation<br>ork done during r<br>use retired)<br>Trator | most of work                | king                                       | 16b. Kind of E                  |                               | vernment  |
| land      | lid be filed<br>fental Hygie<br>rked other<br>lic event, II   | To Be C        | 17. Father's Name (First, Middle, La<br>Lewis Martin   |                                       |  |                                    |                       |   |                             | n Heller                                   |                                 |                               | CLIMICITO   |
| Mary      | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other traumatic   |                | 19a. Informant's Name/Relationshi  |                                       | Wheelston ( )  |                                    |                       |   |                             | ral Route Number                           |                                 |                               |   |
| more,     | Pages 1 a<br>nent of Hea<br>int: if item<br>iry or othe   | 0.0            | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe  | B □Removal from                       | State  | Place of Dispo<br>cemetery, cren   | sition (Nation)       | ame of  |                             | Date 7                                     | 20c. Location                   | - City or To                  |   |
| Baltimor  | permit. Pages<br>Deportment of<br>Important: If i<br>any injury or<br>once.   |                | 21. Signature of Funeral Service 1   | ugan                                  | ,  |                                    |                       |   |                             |  |                                 |                               | nd 21228  |
|           | Physician   |                | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List o<br>Immediate Cause (Final<br>disease or condition                                   | omplications that<br>nly one cause on | caused the deat  | h. Do not ente                     | er the mo             | de of dying, such   | as cardiac                  | or respiratory and                         | est,                            |                               | Approximate<br>Interval Between<br>On, et and Death |
|           | /Medical<br>Examiner  |                | resulting in death)  | Due to                                | (or as a consec  | juence of):                        | SU                    | Penalic   | di                          | iseare                                     |                                 |                               | 5 cms   |
| A.        | ncuted<br>nd<br>transit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c                                     | (or as a consec  | ruence of):                        | // (                  |   |                             |  |                                 |                               | 777   |
| 8/00,     | icate be executed<br>physicien and<br>s the burial-transit  | dical Ex       | resulting in death) Last   | d                                     | (or as a consec  | juence of):                        |                       |   |                             |  |                                 |                               |   |
| O. BOX 6  | sath certiff<br>attending<br>for use as   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  | 1 Live                                | itcome of pregna<br>birth 2 Teta<br>nant at time of co | ıl death 3 □                       | Ectopic  <br>Other (s | pregnancy   |                             |  |                                 | ate of delive                 | ery<br>Day Year                                     |
| cords, P. | law requires that the de<br>as been signed by the<br>2 should be detached   | þ              | Part II. Other significant condition   | s contributing to                     | leath but not res                                      | sulting in the ur                  | nderlying             | cause given in Pa   | art I.                      | 23e. Did to                                |                                 | tribute to th                 | ne cause of death?                                  |
| Ž<br>Z    | The lay<br>ate has<br>page 2  | Completed      |  |                                       |  |                                    |                       |   |                             | 24a. Was a autop: perfor                   |                                 | prior to coldeath?            | psy findings available mpletion of cause of         |
| VIII      | ician:<br>certific<br>ector,  | o Be (         | 25. Was case reterred to medical examiner?   | Hospital:                             |  | I S D (a)                          |                       | Othor   |                             | th (Check only or                          | ne)                             |                               |   |
| on or     | iding Phys<br>th.<br>: After this<br>s funeral dir  | <b>-</b>       | 1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investiga   | 28a. Date<br>( <i>Moi</i>             |  | 28b. Time of<br>Injury             |                       | 28c. Injury at Work?  |                             | ome 5 Resid                                |                                 |                               | v)  |
| DIVISION  | al or Atter<br>s after dea<br>si Director<br>ed in by the   | Certification: | 3 Suicide 6 Could no<br>4 Homicide determin  | 288. Plac                             | e of Injury - At h<br>ling, etc. (Special              | ome, farm, stro<br>fy)             | eet, facto            | ry, office  |                             | 28f. Location (S<br>City or Tow            | treet and Num<br>n, State)      | ber or Rura                   | l Route Number,                                     |
|           | To the Hospital or Attending Piwitin 24 hours after death. To the Funarel Director: After to completely filled in by the tunera | Medical (      | 29a. Certifier Certifying (Check only Medical E  | Physician: To the land man            | e best of my kno<br>pasis of examina<br>oner stated.   | owledge, death<br>ation and/or inv | occurre<br>estigatio  | d at the time, date<br>n, in my opinion,                      | e and place,<br>death occur | and due to the c<br>red at the time, c     | ause(s) and m<br>ate and place, | anner as s                    | tated.<br>the cause(s)                              |
|           | To T  | Σ              | 29b. Signature and title of certifier  | 1                                     | pl   | nsuca                              |                       | D 2   | a                           | a  | 9d. Date signe                  |                               |   |
|           | 104,  |                | 30. Name and address of person w   | ho completed cau                      | se of death (Iter                                      | n 23a) (Type,                      | Print)                | 56  | N.                          | k. //-                                     | p/ /                            | Sa.W                          | (05) hol 128  |
| 200       | Sta<br>Registi  |                | 31. Date filed (Month, Day, Year)  DFC 2   | 2005                                  | gistrar's Signa  | ature                              | norte                 | 1   |                             |  | (1)                             | VV VIV                        |   |

Sunny Brown 05-08659 dl

Amend item#1.23aPIT perMF.0852. 2/27/06 TT Please Type of Print in Black indelible lnk. Ensure All Copies Are Legible. Unpend item# 23a,27,perMe,0851,1/26/06 TT

| hysiciai  |                   | Decedent's Name (First, Middle, L<br>Sonny Brown   | ast)   |  | -   |  |  | 2. Date of De<br>Month                     | aath<br>Day Year  | 3. Time of Death                                   |
|---|-------------------|--|--|--|---|--|--|--|---|--|
| /Medica   | al -              | Sunny  |  |  | Brow  |  |  | Decembe                                    | er 22, 2005   | 2:00 P   |
| xamine  | r                 | 4a. Facility Name (If not institution, g   |  | )  |   |  | m, or Location of D  | eath                                       | 4c. County of Dea   | ath  |
|   |                   | 2031 E. Eager St<br>5. Social Security Number 6.   |  | ge (In yrs. la   |   | Baltim<br>If Under 1 Y                   | ore<br>ear if Under 24   | Hrs. 8 Date of Bir                         |   | rthplace (State or Foreig                          |
| ineral<br>rector  |                   | 220-68-6220  | 1[ <b>X</b> M 2□ F   | 44   | Yrs.  | Months D                                 | ays Hours I  | Hrs. 8. Date of Bir (Month, Da             | 17-61   | Md.  |
|   |                   | Usual Residence of Decedent  |  | 7  |   |  |  |  |   |  |
| ight  | _                 | 10a. State 10b. County   |  | 10c. City  | , Town or Loc   |  |  |  |   | 10d. Inside City Limit                             |
| THE STATE OF  | ectc              | Md. NA   |  | 1  | Balti   |  |  |  | 40 000  |  |
| e di  | 5                 | 10e. Street and Number<br>6832 McClean Bl  | Dv.  |  |   | 10f. Zip Co                              | 234  |  | 10g. Citizen of What C  | country?   |
| TO Z  | era               | 11. Marital Status   | 12. Was Deceden  | t Ever in U.S  | S. 13. W  | as Decedent                              | of Hispanic Origin   | ? (Specify Yes or No                       | )- 14. Race - Am  | erican Indian,                                     |
| item 27 is marked other then "naturel" or iteme 23s or 23s-f ehow other traumatic event, the Madical Examinar must be multiled at | by Fur            | Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces 1  Yes 2  If Yes, Give Year or Dates  | <b>K</b> No  | If  | Yes, specify ☐ Yes 2 🗓                   | Cuban, Mexican, P  | uèrto Rican, etc.)                         | Black, Wh   |  |
| and 1   | ted               | 15. Decedent's   | Education  |  | 16a. Deced  | ent's Usual O                            | ccupation<br>one during most of                                  | working                                    | 16b. Kind of Busines  | s/Industry   |
| - Max   | Completed         | Elementary/Secondary (0-12)  | College (1-4or   | 5+)  | life. D   | O NOT use re                             | etired)  | Working                                    |   |  |
| other the   |                   | GED  17. Father's Name (First, Middle, Las   | n+1  |  | La  | borer                                    | 10 Mathada   | None (First Middle                         | Varies  |  |
| arked of  | Be                | Unkn   | 54)  |  |   |  | Marg   | Name (First, Middle                        | , maiden Sumame)<br>Brown   |  |
| is marked aumatic ev  | ۵.                | 19a, Informant's Name/Relationship   | (Type, Print)  |  | 19b. Mailine  | Address (St                              |  |  | er, City or Town, State,  |  |
| 27 is   |                   | Margie Brown   | Mothe  | r  |   |  |  | Baltimore                                  |   |  |
|   |                   | 20a. Method of Disposition   |  | 1 00   | ace of Dispos<br>emetery, crem                                      | ition (Name o                            | of   | Date                                       | 20c. Location - City o  |  |
| iry or  |                   | 1 SpBurial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec   |  |  | King Me   |  |  | 1-3-06                                     | Randallst   | own, Md.   |
| Important: if<br>eny injury or<br>once.   |                   | 21. Signature of Fundral Service Lic   | ensee  |  | - 1   |  | ddress of Facility   | Balt<br>1101 F                             | imore, Md.<br>E. North Av   | 21202  |
|   |                   | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List only   | mplications that cause   | d the death  | . Do not ente   | r the mode of                            | dying, such as car   |  |   | Approximate<br>Interval Between                    |
| physicien and s the burial-transit  | edicai Examiner   | Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or a  |  |   |  |  |  |   |  |
|   | Physician/Medi    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcom<br>1 □ Live birth<br>4 □ Pregnant<br>9 □ Unknown                     | 2 🗌 Fetal  | death 3 🗌   | Ectopic pregn<br>Other (s <i>pecif</i>   |  |  | 23d. Date of de<br>Month  | olivery<br>Day Year                                |
| be of   | ۵                 | Part II. Other significant conditions Hypothermia  | contributing to death  | but not resu   | iting in the un   | derlying caus                            | e given in Part I.   |  | obacco use contribute l<br>Yes 2 ☐ No 3 ☐ P   | robably 4 Unknow                                   |
| Should  | Completed         |  |  |  |   |  |  |  |   | utopsy findings available completion of cause of s |
| 2 2 1   | Be                | 25. Was case referred to medical exampiner?  | Hospitali  |  |   | -  |  | Death (Check only o                        | one)  |  |
| 2 2 1   |                   |  | Hospital: 1 ☐ Inpat  | ient 2   E   | ER/Outpatient<br>28b. Time of                                       |  |  |  | dence 6 Other (Spe  | ocity) AT Scen                                     |
| his certificate has<br>Il director, page 2  | ၉                 | 1 XXes 2 □ No  |  | ay rear/   | 1:48 P  |  | Injury at<br>Work?<br>1 ☐ Yes 2 🕱 No                             |  | how injury occurred<br>to cold enviro   |  |
| After this certificete has<br>funeral director, page 2  | ၉                 | 1 Stes 2 No  27. Manner of Death  1 Natural 5 Pending  | 28a. Date of In<br>(Month, D   | Y05  |   |  |  | rybosen r                                  |   | INETIC   |
| After this certificate has funeral director, page 2   | ၉                 | 1 XXes 2 No<br>27. Manner of Death   | on 12/22/20  |  |   | et, factory, of                          | fice   | 28f. Location (.<br>City or Ton            | Street and Number or E<br>wn, State) 2031 E   | Bural Route Number,<br>Lager St                    |
| After this certificate has funeral director, page 2   | Certification: To | 27. Manner of Death  28. Accident 3 Suicide 4 Homicide  29a. Certifier (Check only) 2 No 27. Manner of Death 5 Pending investigate 6 Could not determine   | be d 12/22/20 28e. Place of libuiding, vacant  Physician: To the besaminer: On the basis | njury - At horoto. (Specify, Building) t of my know of examination                                 | me, farm, stre  | occurred at the                          | ne time, date and p  | lace, and due to the                       | Street and Number or E<br>wn, State) 2031 E<br>e, MD<br>cause(s) and manner a<br>date and place, and du | s stated   |
| After this certificate has funeral director, page 2   | ၉                 | 27. Manner of Death  13. Natural 2 M Accident 3 Suicide 4 Homicide  29a. Certifier 1 Certifying I  | be de la   | njury - At horoto. (Specify, Building) t of my know of examination                                 | me, farm, stre  | occurred at the estigation, in           | ne time, date and p  | dace, and due to the occurred at the time, | e, MD   | s stated.<br>e to the cause(s)                     |
| el Director: After this certificete has led in by the funeral director, page 2  | Certification: To | 27. Manner of Death  27. Manner of Death  28. Accident  3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying I                              | be d 12/22/20 28e. Place of libuiding, vacant  Physician: To the besaminer: On the basis | njury - At horoto. (Specify, Building) t of my know of examination                                 | me, farm, stre  | occurred at the estigation, in 29c. Li   | ne time, date and p<br>my opinion, death o<br>cense number       | Baltimor                                   | cause(s) and manner a date and place, and du  | s stated. e to the cause(s) th, Day, Year)         |
| After this certificate has funeral director, page 2   | Certification: To | 27. Manner of Death  27. Manner of Death  28. Accident  3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier       | 28e. Place of It Vacant  Physician: To the besaminer: On the basis and manner s          | njury - At honor of the control of the control of the control of the control of examinating tated. | me, farm, stre<br>)<br><b>DG</b><br>wledge, death<br>ion and/or inv | occurred at the estigation, in 29c. Li   | ne time, date and p<br>my opinion, death o<br>cense number       | Baltimor                                   | cause(s) and manner a<br>date and place, and du   | s stated. e to the cause(s) th, Day, Year)         |
| After this certificate has funeral director, page 2   | Certification: To | 27. Manner of Death  27. Manner of Death  28. Accident  3 Suicide 4 Homicide  29a. Certifier (Check only one)  1 Certifying I                              | 28e. Place of It Vacant  Physician: To the besaminer: On the basis and manner s          | njury - At honor of the control of the control of the control of the control of examinating tated. | me, farm, stre<br>)<br><b>DG</b><br>wledge, death<br>ion and/or inv | occurred at the estigation, in a 29c. Li | ne time, date and p<br>my opinion, death o<br>cense number<br>ME | Baltimor                                   | cause(s) and manner a date and place, and du  | s stated. e to the cause(s)  th, Day, Year)  2005  |

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

10a. State

Director

Maryland

11. Marital Status

10e Street and Number

213-30-8553

2614 Pierpont Street

1 Never Married 2 Married

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

Hospita

10b. County

0

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ M 2 🗙 F

N/A

**Physician** 

/Medical

Examiner

**Funeral** 

Director

State of Maryland / Department of Health and Mental Hygiene

Lila Brown

-l'timore

7. Age (In yrs. last birthday,

90

Yrs

10c. City, Town or Location

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Boilt, mose

Hours

Baltimore

21230

Min

Days

10f. Zip Code

Certificate of Death

| imore, Maryland 21215-0036 | permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland |
|----------------------------|--|
| Baltimor                   | permi. Pages   |
|                            | Baltimore, Maryland 21215-0036   |

orient: if Item 27 is marked other than "natural", or Itema 23s or 28s-1 show injury or other traumatic event. The Medical Examinations was be notified as 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: þ 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mendar Hyglene.
Important: If Item 27 is marked other than "
any injury or other traumatic event. Its Ma
ance. College (1-4or 5+) Elementary/Secondary (0-12) Housekeeper 12 17. Father's Name (First, Middle, Last) Early Greene 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2631 Waterview Avenue Baltimore, Maryland 21230 Ruth Sherrill Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 12/31/05 Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Interation /Medical Due to (or as a consequence of): Examiner brillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit Encephal Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes Division of Vital or Attending Physician: illed in by the funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Reg. No. 3. Time of Death 2 Date of Death Year 01:40A M 2005 December 24 4b. City, Town, or Location of Death 4c. County of Death N/A If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) Sep 30, 1915 Virginia 10d. Inside City Limits 1 Yes 2 □ No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Black 16b. Kind of Business/Industry Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) Alice J. Greene 20c. Location - City or Town, State Baltimore, Md. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 - No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

24, 2005

State Registrar

31. Date filed (Month, Day, Year)

2005

32. Registrar's Signature

|   |                | For<br>Stata<br>Ragistrar   | State of   | Maryland  |                                    | artmen<br>rtificate                           |                          |                             | ind M    |  | giene                    | 05 1                                | 2029  |
|---|----------------|---|--|---|------------------------------------|---|--------------------------|-----------------------------|----------|--|--------------------------|-------------------------------------|---|
| Physicia<br>/Medic  |                | 1. Decedent's Name (First, Middle Eliza E   | , Last)<br>Bruce                                       |   |                                    |   |                          |                             |          | 2. Date of Dea<br>Month                          | Day                      | Year<br>2005                        | 3. Time of Death<br>8:45 P                        |
| Examine<br>Funeral  |                | 4a. Facility Name (If not institution Good Samari 5. Social Security Number   | tan Hos  | pital<br>Age (In yrs. las   | t birthday)<br>Yrs.                | 0   | Ltin                     | Location of                 | 2        | 8. Date of Birt<br>(Month, Da                    | h                        |                                     | /A<br>place (State or Fore                        |
| Director  |                | 217-20-7868  Usual Residence of Decedent  10a. State 10b. County  | *  | 80<br>10c. City, 1  |                                    | ocation                                       |                          |                             |          | Feb 22   | 2, 1925                  |                                     | Carolina  10d. Inside City Limi                   |
| with the Maryland a or 28a-f show   | Director       | Maryland  10e. Street and Number  | N/A  |   |                                    | 101 7   |                          | ltimore                     |          |  | 10- 0"                   |                                     | 1 <b>⊠</b> Yes 2 □ N                              |
| 3a or   |                | 1503 Northbourne R  | nad  |   |                                    | 10f. Zip                                      | Code                     | 2123                        | a        |  | rog. Citizi              | en of What Cou<br>U.S./             |   |
| urs a   | d by Funeral   | 11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🙀 Widowed 4 ☐ Divorced   | 12. Was Deced  | ₹ No  | 13.                                | Was Deced<br>If Yes, spec                     |                          |                             |          | cify Yes or No-<br>Rican, etc.)                  |                          | 4. Race - Ameri<br>Black, White     | can Indian,                                       |
| "natu   | Completed      | 15. Decedent<br>(Specify only highes<br>Elementary/Secondary (0-12)   | 's Education<br>t grade completed)  College (1-        |   | (Give                              | dent's Usua<br>kind of wor<br>DO NOT us<br>Te | rk done d<br>se retired  | luring most                 |          | ng   |                          | d of Business/Ir<br>Acme Pad        |   |
| a H H   | To Be C        | 17. Father's Name (First, Middle,   | last)  |   |                                    |   |                          | 18. Mother                  | r's Name | (First, Middle,                                  | Maiden S<br>ta Pete      | ,                                   |   |
| 2 shou<br>and N<br>is ma<br>aumai   |                | 19a. Informant's Name/Relations   | nip (Type, Print)                                      |   |                                    |   |                          |                             |          |  |                          | Town, State, Zi                     | p Code)   |
| and<br>ealth<br>n 27<br>nar tr  |                | Sandra Wade Daug  20a. Method of Disposition  1  Burial 2 Cremation   | 3 □Removal from S                                      | can   | e of Disp                          | 503 Nor<br>osition (Nan<br>matory or o        | ne of                    | 1                           | D        | more, Mar  | -                        | ation - City or T                   |   |
| permit. Pages 1 Department of H Important: If ital any injury or oth  |                | 1 d □ Donation 5 □ Other (S)  21. Signature of Funeral Service  23a. Part1. Enter the disease, or   | icenspe  | ato c   | 2                                  | vridge M<br>2. Name an<br>Fe                  | d Addres                 | s of Facility               | /        | 12/28/05   | РΔ                       | Elkridge                            | e, Md.  |
| /Medical Examiner the prival-transit  | dical Examiner | shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Osquentially is to conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | aAno   | or as a consequence of a | nce of):                           | phalo   | spa                      | thy                         |          |  |                          |                                     | Interval Between<br>Onset and Death               |
| = 0.0   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown   | 1 ☐ Live bir   | ome of pregnanc<br>th 2 □ Fetal di<br>int at time of dea<br>wn  | eath 3[                            | ⊒Ect <i>o</i> pic pr<br>⊒ Other (sp           |                          |                             |          |  | 23                       | 3d. Date of deliv<br>Month          | rery<br>Day Year                                  |
| w requires that been signed I should be det   | ρχ             | Part II. Other significant condition  Acute Rena  | ns contributing to deal                                |   | _                                  | inderlying c                                  | -                        |                             | ذ َ      |  | obacco us<br>(es 2 🗆     |                                     | the cause of death                                |
|   | Completed      | Hypertension  | order  | Diabet<br>e Stro  |                                    |   |                          |                             |          | 1 ☐ Yes  | rmed?<br>2 No            | 24b. Were autoprior to codeath?     | opsy findings avail<br>ompletion of cause<br>2 No |
| Attanding Physician: r death. sector: After this certification by the funeral director.                                     | ation; To Be   | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendin investig  | g 28a. Date o<br>(Month                                | patient 2 EF<br>f Injury 2<br>n, Day Year)  | VOutpatie<br>8b. Time of<br>Injury |   | 8c. Injury<br>Work       | er: 4 □ Nui                 | sing Hon | (Check only o<br>me 5 ☐ Resid<br>28d. Describe h | dence 6                  | Other (Speci                        | ity)  |
| To the Hospital or Attandi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the the | Certification; | 3 Suicide 6 Could a determ  | ined 289 Place   | of Injury - At hom<br>g, etc. (Specify)   | e, farm, st                        | reet, factory                                 | , office                 |                             | 2        | 28f. Location (5<br>City or Tox                  | Street and<br>vn, State) | Number or Rur                       | al Route Number,                                  |
| To the Hospital or Al<br>within 24 hours after o<br>To the Funeral Dirac<br>completely filled in by                         | Medical        | 29a. Certifier 1 M Certifyin (Check only one) 1 Medical   | g Physicien: To the<br>Examiner: On the ba<br>and mann | sis of examinatio   | edge, dea<br>n and/or ir           | th occurred<br>nvestigation                   | at the tim<br>, in my or | e, date and<br>pinion, deat | place, a | and due to the ded at the time,                  | cause(s) a<br>date and p | and manner as s<br>place, and due t | stated.<br>to the cause(s)                        |
| To the To the Complet   | M              | 29b. Signature and title of certifie  | Grang  | /   | 1.D                                |   | RE:                      |                             |          |  | 12                       |                                     | Day, Year)<br>2005                                |
| 6   |                |   | maryland   | L 01.   | 204                                | , Print) G                                    | ood                      | Samo                        | rrita    | n Hosp   | ital                     |                                     |   |
| Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 2 9 200   | 5 22. Re   | gistrar's Signatur  | Book                               | 1   |                          |                             |          |  |                          |                                     |   |

|                         |  | ı              | For State Registrar  | State of Maryland /  |             | tment of Heificate of D                     |                                      | Mental Hy                         | giene<br>Reg: No | 1115  | 42030                                 |  |
|-------------------------|--|----------------|--|--|-------------|---|--------------------------------------|-----------------------------------|------------------|---|---------------------------------------|--|
| e-v-                    | W (1)  |                | 1. Decedent's Name (First, Middle, Last)   |  |             |   |                                      | 2. Date of De                     |                  | V   | 3. Time of Death                      |  |
|                         | Physici<br>/Medic  |                | Edward Harry   | Buddemeyer   |             |   |                                      | Month<br>December                 | Da<br>26 26      | Year 2005                                     | 10:25 pm                              |  |
| 100                     | Examin   |                | 4a. Facility Name (If not institution, give str  |  |             | 4b. City, Town, or                          | Location of Dea                      | th                                |                  | County of Dea                                 |                                       |  |
|                         |  | 地文             | Gilchrist Center fo  | or Hospice   |             | Towson                                      |                                      |                                   | I                | Baltimon                                      | re                                    |  |
| · · ·                   | Funeral  |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last bi  |             | tf Under 1 Year<br>Months Days              | If Under 24 Hrs<br>Hours Min         |                                   | th<br>av. Year)  | 9. Bir  | thplace (State or Foreign ountry)     |  |
|                         | Director   |                | 217–38–8010  | <sup>4 2□ F</sup> 64   | Yrs.        | Wioritis Days                               | 110013                               | 1/17/                             | 941              |   | ryland                                |  |
| 7                       | 2  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Tov   |             |   |                                      |                                   |                  |   | 40d Incide Ob Limite                  |  |
| S                       | o a  | _              | 10a. State 10b. County   | Toc. City, Tov   | WIT OF LOCA | ation                                       |                                      |                                   |                  |   | 10d. Inside City Limits 1 ☐ Yes 2 🛣No |  |
| Z.                      | - 88<br>- 4  | Director       | Maryland Baltimore   | Essex  |             |   |                                      |                                   |                  |   |                                       |  |
| it i                    | or 2   | Dire           | 10e. Street and Number   |  |             | 10f. Zip Code                               |                                      |                                   | 10g. Cit         | izen of What Co                               | ountry?                               |  |
| death with the Maryland | 23   | - E            | 1417 Strawflower Ro  |  |             | 21221                                       |                                      |                                   |                  | S. A.   |                                       |  |
|                         | in in  | Funeral        |  | . Was Decedent Ever in U.S.<br>Armed Forces?                                 | 13. Wa      | as Decedent of His<br>Yes, specify Cubar    | spanic Origin? (:<br>n, Mexican, Pue | Specify Yes or Norto Rican, etc.) | D-               | <ol> <li>Race - Ame<br/>Black, Whi</li> </ol> |                                       |  |
| م پاور                  | 0  | by F           | 1 Never Married 2 Marned 3 Widowed 4 Divorced  | 1 ☐ Yes 2 🛣 No<br>If Yes, Give<br>Year or Dates:                             | 10          | □Yes 2XNo                                   | Specify:                             |                                   |                  | Specify:                                      |                                       |  |
| d Z 1 Z 1 3-0030        | Fra  |                | 15. Decedent's Educa   |  | Docada      | nt's Usual Occupa                           | tion                                 |                                   | 16h K            | WI<br>ind of Business                         | nite                                  |  |
| 2 2                     | 200  | Completed      | (Specify only highest grade  | completed)   | (Give kil   | nd of work done di<br>O NOT use retired)    | uring most of wo                     | orking                            | 10D. K           | ind of business                               | Andustry                              |  |
| Z                       | ene.   | mc             | Elementary/Secondary (0-12)  | College (1-4or 5+)   |             | Driver                                      |                                      |                                   | FO               | od Indus                                      | stru                                  |  |
| D D                     | Hyg<br>the<br>ont,   | Ö              | 17. Father's Name (First, Middle, Last)  |  | Lack        |   | 18. Mother's Na                      | ıme (First, Middle                |                  |   | JCL J                                 |  |
| and<br>Apple            | lental<br>c ev   | To B           | Harry Duddamarray  |  |             |   | Angoli                               | na Kempa                          |                  |   |                                       |  |
|                         | to their traumatic event, the Madical Examinar must be notified at                                 | F              | Harry Buddemeyer  19a. Informant's Name/Relationship (Type   | o, Print) 19   | b. Mailing  | Address (Street a                           |                                      | _                                 |                  | r Town, State,                                | Zip Code)                             |  |
| Ma                      | ith ar<br>27 is<br>1 trau  |                | Funice Annalou Bud   | (Ex Wile)  | 1105        | Sandysto                                    | no Posó                              | λ»+ M                             | Fee              | ov Mar  | ryland 21221                          |  |
| בי בֿ                   | Hea<br>tsm<br>othe   |                | 2ua. Method of Disposition   | 20b. Place   | of Disposit | tion (Name of                               | 1                                    | Date                              |                  | ocation - City or                             |                                       |  |
| MOL                     | t: If I  |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)   | moval from State   |             | ntory or other place<br>rematory            | 1   12/                              | /28<br>)05                        | ובת              |   | Manufand                              |  |
| Saltimol                | artme<br>ortan<br>Injur  |                | 21. Signature of Funeral Service Licensee  |  |             |   |                                      |                                   |                  | THOLE,  | Maryland                              |  |
| ם<br>פ                  | points: Taylor Fand<br>Department of Heali<br>Important: If Itsm 2<br>any Injury or other<br>once. |                | 12.1.105   | 11 25  | Bru         | Name and Address<br>JZCZINSKI               | Funera                               | 1 Home 1                          | PA               | Mary  | land 21221                            |  |
| WINDOWS                 | 5153   |                | 23a. Part 1. Enter the disease, or emplication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate  |  |             |   |                                      |                                   |                  |   |                                       |  |
|                         |  |                | shock, or heart failure. List only one<br>Immediate Cause (Final   | cause on each line.  |             | 1.39  | ,                                    | ,                                 |                  |   | Interval Between<br>Onset and Death   |  |
|                         | hysician<br>/Medical   |                | disease or condition resulting in death)   | LUNB C   |             | CER   |                                      |                                   |                  |   | year                                  |  |
|                         | xaminer  |                |  | Due to (or as a consequence  | or):        |   |                                      |                                   |                  |   | <b>1</b> 2 CO2                        |  |
|                         |  | e e            | Sequentially list conditions, if any, leading to immediate   | Due to (or as a consequence  | of):        |   |                                      |                                   |                  |   |                                       |  |
| Tag )                   | nsit   | Examine        | cause. Enter Underlying<br>Cause (Disease or injury  |  |             |   |                                      |                                   |                  |   |                                       |  |
| , s                     | al-tra   | xai            | that initiated events c. resulting in death) Last  | Due to (or as a consequence  | of):        |   |                                      |                                   |                  |   |                                       |  |
| OX OX/OU,               | physicien and<br>s the burial-transit  | dlcal          |  |  |             |   |                                      |                                   |                  | į   |                                       |  |
| 00                      | phy<br>as the  | edic           | <b>u</b> .   |  |             |   |                                      |                                   |                  |   |                                       |  |
| XO T                    | attending p  | cian/Me        | IF FEMALE: 23b. Was decedent pregnant 23c  | . If yes, outcome of pregnancy   |             |   |                                      |                                   |                  | 23d. Date of de                               | livery                                |  |
| death                   | atte   | ciai           | in the past 12 months? 1 ☐ Yes 2 ☐ No  | 1 Live birth 2 Fetal death 4 Pregnant at time of death                       |             | ctopic pregnancy<br>Other (s <i>pecify)</i> |                                      |                                   |                  | Month   | Day Year                              |  |
| 2 5                     | y the  | Physi          | 9 Unknown  | 9□ Unknown   |             |   |                                      |                                   |                  |   |                                       |  |
| ords, P                 | been signed by the<br>should be detached   | by P           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to |  |             |   |                                      |                                   |                  |   | the cause of death?                   |  |
| COLDS                   | sig.   |                |  |  |             |   |                                      | 11/2                              | Yes 2            | □No 3□P                                       | robably 4 DUnknown                    |  |
|                         | shou   | lete           |  |  |             |   |                                      | 24a, Was                          | an               | 24b. Were a                                   | utopsy findings available             |  |
| The law                 | s has  | Completed      |  |  |             |   |                                      | auto                              | psy<br>ormed?    | prior to death?                               | completion of cause of                |  |
|                         |  | ပို            | 25. Was case referred to medical   |  |             |   | 00 Bloom -/ Do                       | 1 Yes                             | 214No            | 1 Tes   | 2 □ No                                |  |
| OI VICE                 | cert   | O              | examiner?  | spitat:<br>1 ☐ Inpatient 2 ☐ ER/O  | utneticet   | 3□ DOA Othe                                 |                                      | eath Check only<br>Home 5 Res     |                  | 6 Other (Spe                                  | h == 0:=                              |  |
| o a                     | ir this<br>aral di   |                | 27. Manner of Death  |  | Time of     | 28c. Injury<br>Work                         |                                      | 28d. Describe                     |                  | _/\   | icity) MOSPICE                        |  |
|                         | Afte<br>fune   | tlor           | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day Year)  | Injury      |   | ?<br>′es 2 □ No                      |                                   |                  | •   |                                       |  |
| DIVISION                | dea<br>ctor  | flca           | 3 Suicide 6 Could not be   | 28e. Place of Injury - At home, f  | arm, stree  | et, factory, office                         |                                      | 28f. Location                     | Street ar        | d Number or R                                 | ural Route Number,                    |  |
| 5                       | after<br>Dire  | Certification: | 4 Homicide   | building, etc. (Specify)   |             | •   |                                      | City or To                        | wn, State        | ))  |                                       |  |
| allo                    | within 24 hours after death.  To the Funerel Director: After completely filled in by the funer.    |                | 29a. Certifier Physic  | rian: To the best of my knowledg   | e death     | ocurred at the time                         | e, data and plac                     | a and dua to the                  | coima(s)         | and manner s                                  | t etatad                              |  |
| I                       | 24 to Fig.   | edical         | (Check only 2 Medical Examine one)   | <ul> <li>or: On the basis of examination a<br/>and manner stated.</li> </ul> | nd/or inve  | stigation, in my op                         | inion, death occ                     | curred at the time,               | date and         | t place, and due                              | e to the cause(s)                     |  |
| Ę                       | Mithir<br>To th<br>comp.   | Me             | 29b. Signature and title of certifier  |  |             | 29c. License                                | number                               |                                   | 29d. Da          | te signed (Mont                               | h, Day, Year)                         |  |
| ,                       | > F 0  |                | Kelland  | ~ W  |             | DS8   | 303                                  |                                   | Do               | conter  | 27 2005                               |  |
|                         | 1  |                | 30. Name and address of person who com   | pleted cause of death (Item 23a)   | (Type, Pr   | rint)                                       |                                      |                                   |                  | 274790  | _ 4                                   |  |
|                         | 5  |                | Agran Charles no   | 6601 N.  | Cher        | de s  | + BA                                 | more                              | mo               | 21204   | į.                                    |  |
|                         | Sta  | ate            | 31. Date filed (Month, Day, Year)  |  |             | 3 7   |                                      |                                   |                  | /   |                                       |  |
|                         | Registi  |                | DEC 2 9 2005   | 32. Registrar's Signature  | 342         | •   |                                      |                                   |                  |   |                                       |  |

DHMH 17 Rev 1/2001

26,2005

DECEMBER

EDWARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BLANKENSHIP Dav **Physician** Month <04 DECEMBER 26 07=52 M 2005 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARFORD UPPER CHEJA PEAICE MEDICAL CENTER BELAIR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 499 32 7398 71 Yrs. Director Virginia Usual Residence of Decedent 10c. City, Town or Location North 10b. County 10d. Inside City Limits other traumatic event. The Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Carolina McDowell Marion 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a 1730 Honeycutt Road 28752 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Korcean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2X No Specify: δ Specify White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7: th and Mental Hygiene 7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Ship Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Blankenship Lewis Lillie Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 la any Injury or other trai once. Gregory Blankenship (son) 2203 Hyden Court Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 12/29 2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA Richard C. 1407 Old Eastern Avenue Essex Maryland 21221 Joffer, 5. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ALUSE MYOCALDIAL SNFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, PULMONARY 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 StNo 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient 2 | AER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident 24 hours after death Puneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifies 29c. License number 29d. Date signed (Month, Day, Year) 021809 JECEMBER 26, 2005 MD mishyruv

State

DHMH 17 Rev 1/2001

ANKENSHIF

State Registrar 31. Date filed (Month, Day, Year)

PNABHO

33.6 YO MIC NO AO
32. Registrar's Signature

TIMONIOM MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

|            |  |                | 1 - For<br>Stata<br>Registrar  | State of Maryland / Depa  | artment of Health and rtificate of Death   | Mental Hygier  | 2003 42032   |
|------------|--|----------------|--|---|--|--|--|
| 4          | Physici  | an             | 1. Decedent's Name (First, Middle, Last)   | B1665   |  | 3. Time of Death   |  |
|            | /Medic   | cal            | MORRIS 49. Facility Name (If not institution, gives  |   | 4b. City, Town, or Location of Dea   | December ath   | 28 2005 0026 Am  |
|            |  |                | Northwest Hos  |   | Kandalls +   | own  | Baltimore  |
|            | Funeral Director   |                | 5. Social Security Number 6. Sex 134 13  | M 2□F 7. Age (In yrs. last birthday) Yrs.   | Months Days Hours Mir  |  | 9. Birthplace (State or Foreign Country)                   |
|            | ow ow  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Lo   | ocation  |  | 10d. Inside City Limits                                    |
|            | he Mac<br>8e-f eh  | Director       | MD   | Baltin  | more   |  | 1 □ Yes 2 No   |
|            | h with t   | al Dir         | 2020 Few herber  | 1 Ln. Apt. 213  | 21207  | 10g. C   | Citizen of What Country?                                   |
|            | Itame  | Funeral        | 11. Marital Status 1 Never Married 2 Married   | 2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ♥No  | Was Decedent of Hispanic Origin? (<br>If Yes, specify Cuban, Mexican, Pue            | (Specify Yes or No-<br>erto Rican, etc.)                 | 14. Race - American Indian,<br>Black, White, etc.          |
| 5-0036     | 72 hours after death with the Maryland<br>natural', or Itame 23a or 28e-f ahow<br>disal Examinat must be notified at | by             | 3 Widowed 4 Divorced   | tf Yes, Give<br>Year or Dates:  | 1 ☐ Yes 2 No Specify:  |  | Specify: Black   |
| 215-(      | within 72 t<br>ene.<br>then "nate  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary Specoadary (0-12)   | completed)  | dent's Usual Occupation<br>kind of work done during most of w<br>DO NOT use refired) | prking 16b.  | Kind of Business/Industry                                  |
| 12121      | filed with<br>Hygiene.<br>Ather ther   |                | 17 Ather's Name (First, Middle, Last)  | Tre   | 65 (perat  | ame (First, Middle, Maiple                               | anutactory   |
| Maryland   | Mental<br>Mental<br>arked c  | To Be          | Richard Bro  | 195   | Kat  | in dill  | man  |
| Mar        | and 2 sho<br>ealth and n 27 is mu  |                | 194. Informant's hame/Relationship (1)4  | 19b. Mailir<br>25 Wife 2020   | ng Address (Syrie) and Number of F   | Rural Boute Number, City                                 | y or Town, State, Zip Code)                                |
| ore,       | Pages 1 and 2<br>nent of Health<br>int: if item 27 inty or other tra   |                | 20a. Nat/lod of Disposition 1 ★Burial 2 □ Cremation 3 □ Re   | 20b Place of Dispo  | osition (Name of<br>matory of other place)   | Date 20c.  | Location - City or Town, State                             |
| Baltimore, | t. Pa<br>rtmen<br>rtent:   |                | Donation 5 ☐ Other (Specify)  21. Signature of Funer Bervice Lieunse   | Naryland  | Water and Address of Fetallity   | 3-05 La  | iurel, MD  |
| Ba         | permit.<br>Departi<br>Import<br>any inj  |                | Naughn C.  | Greene 8  | 728 Liberty Rd   |  | neral Service<br>Stown, MD 21133                           |
|            | Physician  |                | shock, or heart failure. List only on<br>Immediate Cause (Final  | cations that caused the death. Do not ent e cause on each line.   | er the mode of dying, seeh as cardia   | ac or respiratory arrest,                                | Approximate<br>Interval Between<br>Onset and Death         |
|            | /Medical<br>Examiner   |                | disease or condition resulting in death)   | Due to (or as a consequence of):  |  |  |  |
|            | 4  | Jer.           | Sequentially list conditions, if any, leading to immediate   | Due to (or as a consequence of):  |  |  |  |
| pt         | be executed<br>sician and<br>burial-transit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):  |  |  |  |
| 8760,      | cate be executed<br>physician and<br>the burial-transit  | dical E        | - d  |   |  |  |  |
| 9          |  | /Med           | IF FEMALE:   | 3c. tf yes, outcome of pregnancy  |  |  | 201 201 11   |
| Box        | The law requires that the death certifite has been signed by the attending tee As should be detached for use as      | Physician/Me   | in the past 12 months?  1 Yes 2 No   | 1 Live birth 2 Fetal death 3 □  | Ectopic pregnancy Other (specify)  |  | 23d. Date of delivery  Month Day Year                      |
| P.O        | that the de<br>led by the<br>detached  |                | 9 ☐ Unknown  Part II, Other significant conditions conf  | tributing to death but not resulting in the u   | nderlying cause given in Part I.   | 23e. Did tobacco   | o use contribute to the cause of death?                    |
| Records,   | w requires<br>been sign<br>should be   | ted by         |  |   |  | 1 □ Yes  | 2 No 3 Probably A Unknown                                  |
| Rec        | The law are has by page 2 st   | Completed      |  |   |  | 24a. Was an autopsy performed2                           |  |
| Vital      |  | Be C           | 25. Was case reterred to fedical examiner?   |   | 26. Place of De  | 1  Yes 2 N<br>eath (Check only one)                      | lo 1 □ Yes 2 □ No  |
| of         | Phyer this ral dia   | n: To          | 1 Tyes 2 No  | ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  28a. Date of Injury 28b. Time of                                     |  | Home 5 ☐ Residence                                       |  |
| Division   | tendin<br>leath.<br>tor: Af<br>the fur   | catio          | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be  | (Month, Day Year) Injury  | M 1 Yes 2 No   |  |  |
| Divi       | ospitet or Attendents after death  | Certification: | 4 Homicide determined  | 28e. Place of Injury - At home, tarm, stribuilding, etc. (Specify)  | eet, factory, office   | 28f. Location (Street a<br>City or Town, Sta             | and Number or Rural Route Number,<br>ite)                  |
|            | T 4 m 0  | edical (       | 29a. Certifier 1 Certifying Physic (Check only one)  | ician: To the best of my knowledge, death<br>er: On the basis of examination and/or inv<br>and manner stated. | n occurred at the time, date and place vestigation, in my opinion, death occ         | ce, and due to the cause(<br>curred at the time, date an | s) and manner as stated. nd place, and due to the cause(s) |
|            | To the within 2. To the complet  | Med            | 29b. Signature and title of certifier  | and manner stated.  | 29c. License number  | 29d. D   | Date signed (Month, Day, Year)                             |
|            | /  |                | N. Lawn  | hpleted cause of death (Item 23a) (Type.,   | HOO(1339   | 7 Du   | cember 28, 2005  |
|            | 5  |                | Dr. Langa Harlan   | n 5401 Old GT K   | Ed. Kandallston  | un MD z  | 4133   |
| 130        | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  DFC 2 9 20  | 32. Registrar's Signature   | Carle  |  |  |

| mie                        | Brown  |                            | State 0   | Maryland / Den                                      | artment of Health an  | d Mental Hygier                                  | ne Logizioi                     |                                     |
|----------------------------|--|----------------------------|---|---|---|--|---------------------------------|-------------------------------------|
|                            |  | -                          | For State C Registrar   |   | rtificate of Death  | ,  | 2003                            | 42033                               |
|                            |  |                            | Registrar  1. Decedent's Name (First, Middle, Last)                         |   | Timeate of Death  | Reg."  | No.                             | 3. Time of Death                    |
| -                          | Physicia   | an                         | ,   |   | BROWN   | Month  | Day Year                        | M                                   |
|                            | /Medic   |                            | LENNIE  | nharl   | 4b. City, Town, or Location of D  | December   | 23, 2005<br>4c. County of Death | 2:15 A "                            |
|                            | Examin   | er                         | 4a. Facility Name (If not institution, give street and nur                  | _   |   |  |                                 | 1                                   |
|                            |  |                            | Maryland General Hospit  5. Social Security Number 6. Sex                   | 孔上<br>7. Age (In yrs. last birthday)                | Baltimore City  |  | N/A                             | nplace (State or Foreign            |
|                            | Funeral Director   |                            | 119-57-9482 1□M 2×F   | 5/ Yrs.   |   | Hrs. 8. Date of Birth (Month, Day, Ye  NOV: 15./ |                                 | ITH CAROLINA                        |
| 77                         |  |                            | Usual Residence of Decedent   |   |   | 11000110,1                                       | 177 304                         | THETHELINA                          |
| Maryland                   | Wo #   |                            | 10a. State 10b. County  | 10c. City, Town or Lo                               | ocation   | 0  |                                 | 10d. Inside City Limits             |
| ∑<br>Z                     | Bed  | į                          | MARULAW N/A   |   | BALTIM  | ORE CIT  | -1/                             | 1. Yes 2 □ No                       |
| with the                   | 28<br>F TO   | ire                        | 10e. Street and Number  |   | 10f. Zip Code   |  | Citizen of What Cou             | untry?                              |
| 3                          | 23a  | Funeral Director           | 1171 KITMORE  | ROAD  | 210   | 239  | US                              | A.                                  |
| deeb                       | E E  | iner                       | 11. Marital Status 12. Was Dece<br>Armed Fo                                 | edent Ever in U.S. 13.                              | Was Decedent of Hispanic Origin'<br>If Yes, specify Cuban, Mexican, P                 | ? (Specify Yes or No-<br>uerto Rican, etc.)      | 14. Race - Amer<br>Black, White |                                     |
| 36                         | or it  | 포                          | 1 Never Married 2 Married 1 Yes   | 2 No  | 1 ☐ Yes 2 No Specify:   |  | Specify: (*)                    |                                     |
| 5-0036                     | LEX.   | d by                       | 3 Novidowed 4 Divorced Year or D  | ates:   |   |  | 10                              | LACK                                |
| S ON                       | n die  | Completed                  | 15. Decedent's Education<br>(Specify only highest grade completed)          | 16a. Dece<br>(Give                                  | ident's Usual Dccupation<br>a kind of work done during most of<br>DO NOT use retired) | working 16b                                      | . Kind of Business/l            | ndustry                             |
| 121                        | than<br>than   | Ę.                         | Elementary/Secondary (0-12) College (1                                      | -4or 5+)  |   |  | SELETE                          | may auga                            |
| 121<br>Iled w              | Hygin<br>nt, it  |                            | 17. Father's Name (First, Middle, Last)                                     | DA  |   | VIDER S<br>Name (First, Middle, Maid             | SELF-EI<br>den Sumame)          | MPLOYED                             |
| Maryland                   | to Health and Mental Hygiene.<br>If item 27 is marked other than "natural", or items 23s or 28s-f show<br>or other traumatic avant, the Medical Examiner must be notified at | Be c                       |   | WASHING   | /   | IRSANA   | < r                             | 2007                                |
| <b>&gt;</b>                | d Me<br>mark<br>mati   | <u>٩</u>                   | 19a. Informant's Name/Relationship (Type, Print)                            |   | ing Address (Street and Number o  |  | tv or Town, State, Z            | in Code)                            |
| Z S                        | trau   |                            | ANTOINENA BROWN (DAG  | \   | 1 KITMORE   | RA BAIT  | THEOR MA                        | 1 7/239                             |
| <b>6</b> , 2               | of Health of Itam 27 i   | Ì                          | 20a. Method of Disposition  | 20b. Place of Dispo                                 | osition (Name of  | Date 20c   | Location - City or 1            | Town, State                         |
| <u>Ö</u>                   | nt of  |                            | 1 ⊠Buriai 2 □ Cremation 3 □ Removal from                                    | State   | matory or other place)  | 00 01 -  |                                 |                                     |
| Baltimore,                 | ertmen<br>ortant:<br>injury<br>e.  |                            | 4 □ Donation 5 □ Other (Specify)  21. Signature of Euneral Service Licensee |   | 1. GARDENS CEMETERS D   | -05-00 El  | - LINGHAM                       | 3,6,                                |
| Ba                         | Depertment of important: If it any injury or o   |                            | 7.6111  | Minimo .  | 2. Name and Address of Fi cility  | BROWNTK  | 2                               | 2 2 mm                              |
|                            | Physician<br>/Medical  |                            | 23a. Part1. Enter the disease, or complications that of                     | aused the death. Do not en                          | ter the mode of dving, such as car  |  | BALTOIN                         | Approximate                         |
|                            |  |                            | shock, or heart failure. List only one cause on e                           | ach line.   |   |  |                                 | Interval Between<br>Onset and Death |
| 3"                         |  |                            | disease or condition resulting in death)                                    | lications of al                                     | liverse reaction  | to anesthe                                       | sia                             |                                     |
|                            | xaminer  |                            |   |   |   |  |                                 |                                     |
|                            |  | - G                        |   | or as consequence of):                              |   |  |                                 |                                     |
| (a)                        | Insit  | 듣                          | Cause (Disease or injury  |   |   |  |                                 |                                     |
| ),                         | n and<br>ial-tra   | Examiner                   | that initiated events c. Pue to   | or as a consequence of):                            |   |  |                                 |                                     |
| 760,                       | hysicien and<br>the burial-transit   | cai                        |   |   |   |  | T T                             |                                     |
|                            | attending physi  |                            |   |   |   |  |                                 |                                     |
| Box 68                     | ndin<br>use  | 2                          |   | come of pregnancy                                   |   |  | 23d. Date of deliv              | very                                |
| <b>u</b>                   | e atte   | Cia                        | in the past 12 months?  1 Yes 2 No 4 Pregn                                  | ant at time of death 5                              | □Ectopic pregnancy □ Other (specify)  |  | Month                           | Day Year                            |
| P.O.                       | by th  | hys                        | 9 □Unknown 9□ Unkno   | JWN   |   |  |                                 |                                     |
|                            | been signed by the s   | Completed by Physician/Med | Part II. Other significant conditions contributing to de                    | -   |   |  | co use contribute lo            | the cause of death?                 |
| ords,                      | en sig   | pa                         | Hypertensive atheroxclerot  | c andiavas  | cular disease.  | 1 ☐ Yes  | 2 No 3 □ Pro                    | obably 4 Unknown                    |
| 00 %                       | 2 sho  | piet                       | disbetes mellitus   |   |   | 24a. Was an autopsy                              | 24b. Were aut                   | topsy findings available            |
| Ž į                        | page 2   | E                          |   |   |   | performed  | 2 death?                        | ompletion of cause of               |
| ital                       | certificate<br>rector, pag   | 0                          | 25. Was case referred to medical  |   | 26. Place of  | Death   Check only one                           | 10 100                          | 20.0                                |
| Division of Vital Records, | is ce<br>direc   | To B                       | examiner?<br>Yes 2 No Hospital:   | npatient 2 ER/Outpatie                              | nl 3 DOA Other: 4 Nursin  | ng Home 5 Residence                              | 6 ☐Other (Spec                  | ify)                                |
| 0 4                        | ter th   | Ë                          | 27. Manner of Death 1 □ Natural 5 □ Pending (Mon.                           | of Injury 28b. Time of Injury Injury                |   | 28d. Describe how in                             | njury occurred                  |                                     |
| Vision                     | ath.<br>or: Af   | atic                       | 20 Accident investigation Dec 12  | 12005 1:05  | p M 1 ☐ Yes 2 No  | adverse read                                     | chon to or                      | restlesia                           |
| Vis                        | er de<br>recto   | ₽<br>E                     | 3 Suicide 6 Could not be 28e. Place determined buildi                       | of Injury - Al home, farm, st<br>ng, etc. (Specify) | reet, factory, office   | 28f. Location (Street<br>City or Town, St        | and Number or Ruitate)          | ral Route Number,                   |
|                            | is aft<br>ed in  | Certification;             |   | hospital  |   | 827 Linden                                       |                                 | nove, MD                            |
| O S C                      | within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,   | cai                        | 29a. Certifier (Check only 2 Madical Examinar: Dn the b                     | best of my knowledge, dear                          | th occurred at the time, date and p   | lace, and due to the cause                       | and place, and due              | stated.                             |
| 4                          | in 24  | Medicai                    | one) and man  | ner stated.   |   |  |                                 |                                     |
| Į,                         | With<br>To   | 2                          | 29b. Signature and title of certifier                                       | 2   | 29c. License number   | 29d.   | Date signed (Month              | , Day, Year)                        |
| •                          | $\sim$   |                            | 1 Jabuy Deel  | ND  | OCME  | D  | ecember 2                       | 3, 2005                             |
|                            | 7  |                            | 30. Name and address of person who completed carls                          |   |   |  |                                 |                                     |
|                            |  |                            |   |   | more, Maryland 2  | 21201  |                                 |                                     |
|                            | Sta  |                            |   | egistrar's Signature                                | porte   |  |                                 |                                     |
|                            | Registr  | ar                         | DEC 2 9 2005  | Gregues S.F. A                                      |   |  |                                 |                                     |

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| BRUGH<br>35   |                  | Unpend   | Pleas<br>item#23a               | e Type or Pr<br>PLL 27 perME<br>State of M                      | int in Black<br>(851,1/30/0             | indelible                            | Ink. E                      | Ensure A                            | II Copies                       | Are                                  | Legible.                    |  |  |
|---|------------------|--|---------------------------------|---|---|--------------------------------------|-----------------------------|-------------------------------------|---------------------------------|--------------------------------------|-----------------------------|--|--|
|   |                  | For<br>State<br>Registrar  |                                 | State of W  |   | Certificate                          |                             |                                     | nemarry                         | Reg. No                              |                             | 42034  |  |
| Physicia  | 30               | 1. Decedent's Name   | e (First, Middle,               | Last)   |   |                                      |                             |                                     | 2. Date of Di<br>Month          | eath<br>Da                           | y Year                      | 3. Time of Death                                   |  |
| /Medic  |                  | James E. Brugh   |                                 |   |   |                                      |                             |                                     | DECEME                          |                                      | 5, 200                      |  |  |
| Examin  | er               | 4a. Facility Name (If not institution, give street and number)   |                                 |   |   |                                      |                             | cation of Death                     |                                 |                                      | . County of De<br>BALTIMOI  |  |  |
| Funeral   |                  | FRANKLIN SQUARE HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,                                |                                 |   |   |                                      |                             | Under 24 Hrs.                       | 8. Date of Bi                   | rth                                  | 9. B                        | irthplace (State or Foreign                        |  |
| Director  |                  | 220-27-3456  12 M 2 F 15  Yrs. Months Days Hours Min. (Month, Day, Year) March 15,1990                                   |                                 |   |   |                                      |                             |                                     |                                 | 990                                  | MD MD                       |  |  |
| and   | Funeral Director | Usual Residence of<br>10a. State   | f Decedent<br>10b. County       |   | 10c. City, Town                         | or Location                          |                             |                                     |                                 |                                      |                             | 10d. Inside City Limits                            |  |
| Mary<br>-1 sho  |                  | MD   | Balt                            | timore  | P                                       | arkvill                              | e                           |                                     |                                 | 1 ☐ Yes 2 📉 No                       |                             |  |  |
| or 28e  |                  | 10e. Street and Number   |                                 |   |   |                                      | 10f. Zip Code 10            |                                     |                                 |                                      |                             | Country?   |  |
| 23a c   | rai              | 9211 Ki  | ngstree                         |   |   |                                      | 21234                       |                                     |                                 |                                      |                             |  |  |
| lteme<br>Iteme  | une              | 11. Marital Status   | ind OO Marris                   | 12. Was Deceder   | ;?                                      | 13. Was Decede<br>If Yes, speci      | ent of Hispa<br>fy Cuban, N | anic Origin? (Sp<br>Mexican, Puerto | ecify Yes or No<br>Rican, etc.) | 0-                                   | 14. Race - Arr<br>Black, Wh |  |  |
| urs aft   | by F             | 3 ☐ Widowed  | ried 2 ☐ Marrie<br>4 ☐ Divorced | ed 1 ☐ Yes 21X<br>If Yes, Give<br>Year or Dates                 |   | 1 ☐ Yes 2                            | X No S                      | Specify:                            |                                 |                                      | Specify:                    | White  |  |
| 72 hou  | ted              | (Spec  | 15. Decedent's                  | s Education<br>grade completed)                                 | 16a. D                                  | ecedent's Usual                      | Occupation                  | n<br>na most of work                | cina                            | 16b. K                               | and of Busines              | s/Industry   |  |
| ne.   | Completed        | Elementary/Seco  |                                 | College (1-4o   | r 5+)                                   | Give kind of work<br>ife. DO NOT use |                             |                                     | <b>y</b>                        |                                      |                             |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinating the notified at SARE.          | Co               | 10<br>17. Father's Name  | (First, Middle, L               | ast)  |   | Studen                               |                             | 3. Mother's Nam                     | e (First, Middle                | . Maider                             | Sumame)                     |  |  |
| id be<br>entai<br>ked o<br>Ic eve   | To Be            |  |                                 |   |   |                                      |                             |                                     | L. Stre                         | ett                                  |                             |  |  |
| shou<br>and M<br>mar  | ř                | 2 John W. Brugh  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Bural Rout |                                 |   |   |                                      |                             |                                     |                                 |                                      |                             |  |  |
| and 2<br>Balth<br>m 27 I  |                  | John W.  |                                 | Father  |   | 02 Cars                              |                             | - 24 to 12                          | -                               |                                      |                             |  |  |
| ges 1<br>t of H<br>if Item<br>or oth  |                  | 20a. Method of Disposition 1 Table 2   | •                               | 3 Removal from Stat   | camatan                                 | Disposition (Nam<br>crematory or oti | e of<br>her place)          |                                     | Date                            | 20c. L                               | ocation - City o            | r Town, State                                      |  |
| rtmen<br>rtmen<br>rtent:<br>njury   |                  | 4 ☐Donation 21. Signature of Fu  | 5 Other (Sp                     |   | Rose Hi                                 | 11 Ceme                              |                             |                                     | 29/05                           |                                      | erstown                     |  |  |
| Depe<br>Impo<br>any l   |                  | 21. Signature of Fy  | 20 hou                          | MI.   | ankins                                  |                                      |                             | al Home                             |                                 |                                      |                             | stown Road<br>MD 21136                             |  |
|   |                  | 23a. Part1. Enter  | the disease, or o               | complications that cause  | ed the death. Do no                     |                                      |                             |                                     |                                 |                                      |                             | Approximate<br>Interval Between                    |  |
| Physician   |                  | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Acute pneumonia  |                                 |   |   |                                      |                             |                                     |                                 |                                      |                             |  |  |
| /Medical<br>Examiner  |                  | resulting in death)  Due to (or as a consequence of):  |                                 |   |   |                                      |                             |                                     |                                 |                                      |                             |  |  |
| LAGIIIIICI  | _                | Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):                             |                                 |   |   |                                      |                             |                                     |                                 |                                      |                             |  |  |
| uted<br>insit   | Examiner         | Cause (Disease or  | injury                          |   | a a consequence of                      |                                      |                             |                                     |                                 |                                      |                             |  |  |
| e executed<br>tien and<br>urial-transit   | Exa              | that initiated events<br>resulting in death)   |                                 | c.<br>Due to (or a  | s a consequence of                      | ):                                   |                             |                                     |                                 |                                      |                             |  |  |
| eath certificate be execu<br>ettending physicien and<br>for use as the burial-tra   | Ical             |  |                                 | d   |   |                                      |                             |                                     |                                 |                                      |                             |  |  |
| ertifica<br>Jing pl   | Physician/Medi   | IF FEMALE:   | -                               | 22a If was outcome  | a of proposes                           |                                      |                             |                                     |                                 |                                      |                             |  |  |
| ettenc<br>for us  | clan/            | 23b. Was decedent pregnant in the past 12 months?  |                                 |   |   |                                      |                             |                                     |                                 | 23d. Date of de<br>Month             |                             | elivery<br>Day Year                                |  |
| at the de<br>by the<br>stached  | nyste            | 1   Yes 2   No 9   Unknown 9   Unknown   |                                 |   |   |                                      |                             |                                     |                                 |                                      |                             |  |  |
| res that<br>igned b<br>be deta  | by Pł            |  |                                 |   |   |                                      |                             |                                     | use contribute                  | se contribute to the cause of death? |                             |  |  |
| w require<br>been sig<br>should b   | led t            | Seizure Disorder   |                                 |   |   |                                      |                             |                                     |                                 | Probably 4 Unknown                   |                             |  |  |
| law r<br>nes be<br>s 2 sh   | Completed        | Congenital   | Malfonna                        | tion of Brain   |   |                                      |                             |                                     | 24a. Was                        | psy                                  | prior to                    | autopsy findings available ocompletion of cause of |  |
| sicien: The law<br>scertificete hes l<br>irector, page 2 s  | Cou              |  |                                 |   |   |                                      |                             |                                     | 1 Yes                           | ormed?                               | death?                      | s 2 No   |  |
| Physicien:<br>this certificantal director,  | Be C             | 25. Was case refer examiner?   |                                 | Hospital:   |   |                                      | Othor                       | 6. Place of Deat                    |                                 |                                      | - 524 12                    | · · ·  |  |
| Phys<br>eral di   | n: To            | 1 Inpatient 2 Device 1 DOA 4 Nursing Home 5 Hesidence 6 Other (Specific  |                                 |   |   |                                      |                             |                                     |                                 | ecify)                               |                             |  |  |
| ath.<br>r: Afte   | atlo             | 1 Anatural 2 Accident  | 5 Pending investigation         |   | Day Year) Inj                           | M M                                  |                             | 2 🗆 No                              |                                 |                                      |                             |  |  |
| ter de<br>irecto  | Certification:   | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 ☐ Could n<br>determin         | and 286. Place of I   | njury - Al home, farn<br>etc. (Specify) | n, street, factory,                  | office                      |                                     | 28f. Location<br>City or To     |                                      |                             | Rural Route Number,                                |  |
| plted c   |                  | 20- C-4#   | 45 0-44 -                       | Photoire T. W. I.   |   | 4                                    |                             |                                     |                                 |                                      |                             |  |  |
| To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificete hes been signed by the ettending physicie completely filled in by the funeral director, page 2 should be detached for use as the bur | edical           | 29a. Certifier<br>(Check only<br>one)  |                                 | Physician: To the best<br>examiner: On the basis<br>and manner: | of examination and/                     |                                      |                             |                                     |                                 |                                      |                             |  |  |
| within<br>To the  | Me               | 29b. Signature and   | title of certifier              |   |   | 29c.                                 | License nu                  |                                     |                                 |                                      | ite signed (Mor             |  |  |
|   |                  | •  | Y                               | 11  |   |                                      | OCME                        | 3                                   |                                 | DECI                                 | EMBER 2                     | 6, 2005  |  |
|   |                  | 30. Name and addi  | ress of rson                    | o completed cause of  | death (Item 23a) (T                     | ype, Print)                          | ייויניוניוני                | DATEST.                             | NDT: 3443                       | יא דעצט                              | VIII) 010                   | 01   |  |
| 000   |                  | 31. Date filed (Mon  | oth Day Your                    | 32 Begis  | strar's Signature                       |                                      | CEET,                       | BALTIM                              | JKE, MAI                        | K L L A                              | ND, ZIZ                     | OT   |  |
| Sta<br>Registr  |                  | •  |                                 | 2005  | strar's Signature                       | perk)                                |                             |                                     |                                 |                                      |                             |  |  |
|   |                  |  |                                 | -   |   |                                      |                             |                                     |                                 |                                      |                             |  |  |

|              |  |                      | For<br>State<br>Registrar  | State of Marylan  |                                 | artment of H<br>tificate of L                                      |  |  | giene 05                 | 42035  |
|--------------|--|----------------------|--|---|---------------------------------|--|--|--|--------------------------|--|
|              | Physici  | an                   | 1. Decedent's Name (First, Middle, L   |   |                                 |  |  | 2. Date of Dea                             | ath<br>Day Year          | 3. Time of Death                                   |
|              | Physicia<br>/Medic   |                      | Barbara  |   | Blue                            |  |  | Decembe                                    |                          | 8:31 p <sup>M</sup>                                |
|              | Examin   | er                   | 4a. Facility Name (If not institution, g   |   |                                 | 4b. City, Town, or<br>Takoma                                       |  | Death                                      | 4c. County of Dea        |  |
|              |  |                      | Washington Adve  | Sex 7. Age (In yrs. i   | last birthday)                  | If Under 1 Year  | If Under 24  | Hrs. 8. Date of Birt                       | Montgomer                | - y<br>thplace (State or Foreign                   |
|              | Funeral<br>Director  |                      | 229-54-0971  | 1□M 2⊠F 63  | Yrs.                            | Months Days  | Hours A  | July 12                                    | y, Year) Co              | ountry)  |
|              | ס  |                      | Usual Residence of Decedent  |   |                                 |  |  |  | , ,                      |  |
|              | arylar<br>show   | -                    | 10a. State 10b. County   |   | y, Town or Lo                   |  |  |  |                          | 10d. Inside City Limits 1 X Yes 2 □ No             |
|              | Me M.  | Director             | MD Montgom  10e. Street and Number   | ery Ta  | koma P                          |  |  |  | 10g. Citizen of What Co  |  |
|              | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or llems 23a or 28e-f show<br>ther than "natural", or llems 23a or 28e-f show<br>ant, the Medical Examinat her collined at   |                      | 790 Fairview Ave   | #210  |                                 | 10f. Zip Code<br>2091  | 1.2  |  | USA                      | ountry?  |
|              | ns 23  | Funeral              | 11. Marital Status   | 12. Was Decedent Ever in U.                                       | .S. 13. 1                       |  |  | ? (Specify Yes or No<br>uerto Rican, etc.) |                          |  |
| ധ            | or Iter  | 표                    | 1 Never Married 2 Married  | Armed Forceş?<br>1 ☐ Yes 2 ☐ No                                   | ì                               |  |  | uerto Rican, etc.)                         |                          | te, etc.   |
| ğ            | ral', c  | d by                 | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                                    |                                 | 1 ☐ Yes 21X No   | Specify:   |  | Specify: I               | Black  |
| 21215-0036   | 72 h<br>"natu  | Completed            | 15. Decedent's<br>(Specify only highest of   | Education<br>grade completed)                                     | (Give                           | ient's Usual Occupa<br>kind of work done of<br>DO NOT use retired. | furing most of   | working                                    | 16b. Kind of Business    | /Industry  |
| 7            | withir<br>ane.<br>than   | ш                    | Elementary/Secondary (0-12) 12th   | College (1-4or 5+)  |                                 | ing Speci  |  |  | Dept. of Ag              | riculture  |
| р<br>5       | Hygid<br>Hygid<br>other<br>ant, I  | ပိ                   | 17. Father's Name (First, Middle, La   | est)  | TTTTC                           | ing opeci  |  | Name (First, Middle,                       |                          | griculture   |
| Maryland     | lid be<br>lental<br>ked c  | To Be                | unknown  |   |                                 |  | Beatri   | ce Gardne                                  | r                        |  |
| ary          | shou<br>and N<br>s mai   | -                    | 19a. Informant's Name/Relationship   | (Type, Print)   | 19b. Mailir                     | ng Address (Street a   | and Number o   | r Rural Route Numbe                        | ar, City or Town, State, | Zip Code)  |
|              | and 2<br>salth a<br>n 27 i   |                      | Chery1 Blue/Daug   |   | The second second second        | Osborn Ro  |  | everly, MD                                 | . 20785                  |  |
| ore          | of He of He item   |                      | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3  | □ Removal from State  | Place of Dispo<br>emetery, crer | sition (Name of<br>matory or other place                           | θ)   | Date                                       | 20c. Location - City or  | Town, State  |
| Ē            | Pages<br>Iment of I<br>tant: If it   |                      | *4 □ Donation 5 □ Other (Spe   | cify) Ft.   |                                 | n Cemeter  |  | 2-28-2005                                  | Brentwood,               | Md.  |
| Baltimore,   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show amportant or other traumatic event. I'm Medicul Exarti ner instal be routified at once. |                      | 21. Signature of Funeral Service Lic   | ushall  |                                 | Name and Address<br>arshall s<br>217 9th S                         |  | al Home,<br>Washin                         | Inc.<br>gton, DC 20      | 0011   |
|              |  |                      | 23a. Parf. Enter the disease, or co<br>sheck, or heart failure. List on                                  | omplications that caused the death<br>ify one cause on each line. | h. Do not ent                   | er the mode of dying   | g, such as car   | rdiac or respiratory ar                    | rrest,                   | Approximate<br>Interval Between<br>Onset and Death |
|              | Priysician   | 9 A                  | Immediate Cause (Final disease or condition resulting in death)  | _a Septic   | Sh                              | ock  |  |  |                          | Chistic and Doubl                                  |
|              | /Medical Examiner  |                      | resulting in deathy  | Due to the as a consequ   | uence of):                      | Fa   | 10101  | 0  |                          |  |
|              |  | Fi                   | Sequentially list conditions,  | b. Due to lor at a consequ  | uence of):                      | 7 100  |  | _  |                          | -  |
|              | uted<br>d<br>ansit   | Examiner             | Sequentially list conditions, any cause. Enter Underlying Cause (Disease or injury that initiated events | Chrow   | we                              | RUMO   | I FO   | e<br>ulire                                 |                          |  |
| ó            | exec<br>an an  |                      | resulting in death) Last   | Due to (or as a consequence)                                      | uence of):                      | 00   |  |  |                          |  |
| 8760,        | death certificate be executed attending physician and affor use as the burial-transit  | by Physician/Medical |  | d. Obstac   | 4300                            | Thee   | 00   | vpriso                                     | 1                        |  |
| 9            | leath certifics<br>attending pt<br>I for use as t  | Med                  | IF FEMALE:   |   | -                               |  |  |  |                          |  |
| Box          | ath cattend  | lan/                 | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome of pregna 1 Live birth 2 Feta                | I death 3                       | Ectopic pregnancy  |  |  | 23d. Date of de<br>Month | livery<br>Day Year                                 |
| o.           | that the death<br>ed by the atte<br>detached for   | ysic                 | 1 ☐ Yes 2 ☐ No<br>9 🛣 Unknown  | 4∏Pregnant at time of di<br>9☐ Unknown                            | eaun 5L                         | Other (specify)  |  |  |                          |  |
| صَ           | The law requires that the tite has been signed by the bage 2 should be detache   | y Ph                 | Part II. Other significant conditions  | s contributing to death but not res                               | ulting in the u                 | nderlying cause give   | en in Part I.  | 23e. Did to                                | obacco use contribute to | the cause of death?                                |
| rds,         | quires<br>n sigr   |                      |  |   |                                 |  |  | 101  | res 2□No 3□P             | robabły 4 Onknown                                  |
| Vital Record | aw require<br>s been sign  | Completed            |  |   |                                 |  |  | 24a. Was                                   |                          | topsy findings available                           |
| Ä            | The la   | E                    |  |   |                                 |  |  | — autop<br>perfo<br>1  Yes                 | rmed? death?             | completion of cause of                             |
| ita          | ian:<br>artifica<br>ctor, p  | Bec                  | 25. Was case referred to medical examiner?   |   |                                 |  | 26. Place of   | Death (Check only o                        | - / /                    |  |
| of <         | Physician:<br>this certific<br>ral director,   | မ                    | 1 ☐ Yes 2 ☐ No   | 1   | ER/Outpatier                    |  | 4 LI NUISII  | -  | dence 6 Other (Spe       | cify)  |
| o u          | ing P  | lon:                 | 27. Manner of Death 1 Natural 5 □ Pending  | 28a. Date of Injury<br>(Month, Day Year)                          | 28b. Time of<br>Injury          | Work   | </td <td>28d. Describe h</td> <td>now injury occurred</td> <td></td> | 28d. Describe h                            | now injury occurred      |  |
| isio         | Attending<br>ir death.<br>ector: After<br>by the fune  | icat                 | 2  Accident investigat 3  Suicide 6  Could no  | t ho  | ome farm str                    |  | Yes 2 □ No   | 28f Location (5                            | Street and Number or R.  | ural Route Number                                  |
| Division     | after<br>Direction by  | Certification:       | 4 ☐ Homicide determine   | 28e. Place of Injury - At he building, etc. (Specify              | y)                              | eet, ractory, onice  |  | City or Tov                                | vn, State)               | 3741710310743117507,                               |
|              | To the Hospital or Attending Physician: The lawinin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   |                      |  | Physician: To the best of my kno                                  |                                 |  |  |  |                          |  |
|              | n 24 in Pletel   | edical               | (Check only 2 Medical Ex   | caminer: On the basis of examina<br>and manner stated.            | tion and/or in                  | vestigation, in my or  | oinion, death o  | occurred at the time,                      | date and place, and due  | to the cause(s)                                    |
|              | To the within 2 To the complet   | Ž                    | 29b. Signature and title of certifier  |   |                                 | 29c. License   |  | 1  | 29d. Date signed (Mont   |  |
| ,            | 01   |                      | , sim  |   |                                 | D46  | 099  | 8  | sicem k                  | ere 20,2005  |
|              | 6  |                      | 30. Name and address of person with STUUM T  | - Teo, MD   | 3415                            | Print) HAM   | 11ton  | ST HYAL                                    | foulle M                 | ere 20,2005<br>10 20782                            |
|              | Sta<br>Registi   |                      | 31. Date filed (Month, Day, Year) DEC 2 9 20   | 32. Registrar's Signa   | ture                            | No.  |  | /  |                          | •  |
|              |  |                      | 000 000  | Mark Mark   | - 1                             |  |  |  |                          |  |

|  | Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.  |
|--|--|
|  | State of Maryland / Department of Health and Mental Hygiene  1- State Registrar  Certificate of Death  Reg. Ro. 05  42036  |
| 4 4 5  | Registrer  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death  |
| Physician<br>/Medical  | Tillie Barbara Bertrand 12 27 2005 11-30A  |
| Examiner   | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death   |
| Funeral  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)  |
| Director   | Usual Residence of Decedent  |
| with the Maryland<br>a or 28a-f show<br>Le ricillified at  | 10a. State       10b. County       10c. City, Town or Location       10d. Inside City Limits         Maryland       Baltimore       Nottingham       1 □ Yes 2 ⋈ No  |
| vith the Mar<br>t or 28a-f at<br>te notified<br>Director   | Maryland Baltimore Nottingham  106. Street and Number 107. Zip Code 10g. Citizen of What Country?  |
| 23a of   | 4300 Cardwell Avenue, #125 21236 U.S.A.  |
| Since death virthers 23st thems 23st three must  | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Marned 1 Yes 2 N No  1 Never Married 2 Marned 5 N No  1 Never Married 2 Marned 5 N No  1 Nover Married 2 N Market N Nover Married 2 N No  1 Nover Married 2 N N N N N N N N N N N N N N N N N N   |
| )<br>336<br>11.0<br>by   | 1 □ Never Married 2 □ Married 1 □ Yes 2 No   1 □ Yes 2 No   Specify: Specify: White  |
| 7 / 21215-00 ed within 72 hou yajiene. Institute institute in the institut | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)  |
| Maryland 2121 12 should be filled within h and Mental Hygiene. 7 Is marked other then "traumatic event, traum.   | Elementary/Secondary (0·12) 12th Grade College (1-4or 5+) Homemaker Own Home   |
| be file  | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  Stephania Novotnu   |
| Marylan of 2 should be not a should be should be stored for treatments every treatment every ever | Frank Klipner  Stephania Novotny  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |
| e, Ma 1 and 2 s Health ar em 27 le ther trau   | Joseph Bertrand (son) 9801 Forge Park Rd., Perry Hall, MD 21128  |
| o se o i   | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, creating or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  |
| Baltim   | 4 Donation 5 Other (Specify) Most Holy Redeemer 12/30/2005 Baltimore, Maryland  21. Signature of Funeral Service Lice See 22. Name and Address of Facility Schimunek Funeral Homes   |
| Balt Balt permit. Deportit Importations on ying  | Fin D fin 9705 Belair Rd., Baltimore, MD 21236   |
| Physician<br>/Medical<br>Examiner  | 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death Onset an |
| 760, te be executed ysicien and e burial-transit cal Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):   |
| Records, P.O. Box 687 The law requires that the death certificate site has been signed by the attending physoage 2 should be detached for use as the completed by Physician/Medic  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   |
| ds, F<br>uires tha<br>r signed<br>Id be del  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No 3   Probably 4   Unknown  |
| Division of Vital Records, to Attending Physicien: The law requires that death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by   | 24a. Was an autopsy findings available prior to completion of cause of death?  |
| ta! In The Uniticate or. page of Co  | 1   Yes 2   No   1   Yes 2   No   25. Was case referred to medical   26. Place of Death (Check only one)   |
| of Vita<br>hysician<br>his certifi<br>t director   | examiner?  1   |
| On O<br>ling Pt<br>After th<br>funeral   | 27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  1 Natural 5 Injury investigation  1 Yes 2 No   |
| Division of Vital Recommends to the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Comp  | Accident investigation  3 Suicide 6 Could not be determined 5 Home, farm, street, factory, office building, etc. (Specify)  286. Place of Injury - At home, farm, street, factory, office City or Town, State)   |
| Dospital or hours af ineral by filled in all Cel   | 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |
| o the Hospi<br>ithin 24 hou<br>the Funer<br>implately fill<br>Medical  | (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29d. Date signed (Month, Day, Year)  |
| T W T S O O O  | 29b. Signature and title of certifier  29d. Date signed (Month, Day, Year)  R S S O O O O O O O O O O O O O O O O O  |
| 10   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Chintan Desar 9000 Fron Klin Square Drive Baltimore MD26   |
| State  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |

|                                       |   | •                   | For<br>State<br>Registrar  | State of Marylan   |                                  | irtment of H  |  |                                  | giene 05  | 42037  |  |  |
|---------------------------------------|---|---------------------|--|--|----------------------------------|---|--|----------------------------------|---|--|--|--|
|                                       | Dhusisi   | 4                   | Decedent's Name (First, Middle, Las  | 1)   |                                  |   |  | 2. Date of Dea                   |   | 3. Time of Death                             |  |  |
| 3                                     | Physicia<br>/Medic  |                     |  | Robert Lee   | Baker                            |   |  | Decemb                           |   | - 9  |  |  |
|                                       | Examin<br>Funeral   | 1888F               | 4a. Facility Name (If not institution, give 5 + AG hes.  5. Social Security Number 6. S.   | Hospital 7. Age (In yrs.)  |                                  | If Under 1 Year Months Days                         | If Under 24 Hrs. Hours Min.                | 8. Date of Birt                  | y, Year) (                                      | irthplace (State or Foreign                  |  |  |
| -                                     | Director  |                     | 070-32-0113 Usual Residence of Decedent  | 65   | Yrs.                             |   |  | 9-11                             | -1940   | Va   |  |  |
|                                       | yland<br>how  |                     | 10a. State 10b. County   | 10c. City  | y, Town or Lo                    | cation  |  |                                  |   | 10d. Inside City Limits                      |  |  |
|                                       | Be-fa   | ctor                | Md N/  | A E  | Balto                            |   |  |                                  |   | 1 X Yes 2 □ No                               |  |  |
|                                       | with the or 2   | Dire                | 10e. Street and Number<br>1539 Poplar Grov   | e Street   |                                  | 10f. Zip Code 2121                                  | 6  |                                  | 10g. Citizen of What (                          | Country?                                     |  |  |
| 036                                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23s or 28s-f show apprintury or other traumatic event, I'm M. dical Ext. Inferf. and Itemselfied at ODGs. | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 🖫 Widowed 4 Divorced  | 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 MÃNo If Yes, Give Year or Dates:           | 1                                | Nas Decedent of Hi<br>f Yes, specify Cuba           |  | ecify Yes or No<br>Rican, etc.)  |   |  |  |  |
| 2-0                                   | 72 ho   | eted                | 15. Decedent's Ed<br>(Specify only highest gra   |  | (Give                            | lent's Usual Occupa                                 | during most of work                        | ing                              | 16b. Kind of Busines                            | s/Industry                                   |  |  |
| Maryland 21215-0036                   | od within rgiene.   | Completed           | Elementary/Secondary (0-12)<br>10th grade  | College (1-4or 5+) N/A   | life. L                          | cepreneau   | r  |                                  | Construct                                       | ion  |  |  |
| and                                   | ntal Hy<br>ad oth   | Be                  | 17. Father's Name (First, Middle, Last)  Levi Moore  |  |                                  |   | 18. Mother's Nam  Julia A                  |                                  | Maiden Sumame)                                  |  |  |  |
| ĬŽ                                    | should<br>nd Me<br>mark<br>maric  | 2                   | 19a. Informant's Name/Relationship (   | ype, Print)  | 19b. Mailin                      | g Address (Street a                                 |  |                                  | r, City or Town, State                          | Zip Code)                                    |  |  |
| Ž,                                    | and 2<br>alth a<br>1 27 is  |                     | Robin Baker - Da   | ughter   | `104                             | Woodlay   | m Avenue                                   | Jersey                           | City, N.  | .1_ 07305                                    |  |  |
| altimore,                             | Pages 1 i   |                     | 20a. Method of Disposition  1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   | Removal from State   | emetery, cren                    | sition (Name of<br>natory or other plac<br>Cemetery | 12-2                                       | 8-2005                           | Lansdown,                                       | or rown, State                               |  |  |
| Balt                                  | Depart<br>Depart<br>Import<br>any inj   |                     | 21. Scrature of Funeral Service Licen  | Mugut  |                                  |   | 4300 Waba                                  |                                  | ue Balto,                                       | Md 21215                                     |  |  |
|                                       | Physician<br>/Medical   |                     | 3a. P. rt1. Enter the disease, or com,<br>nock, or heart failure. List only<br>m. diate Cause (Final<br>lise se or condition<br>by fitting in death) |  |                                  | chil<br>Cardio                                      |  |                                  |   | Approximate Interval Between Onset and Death |  |  |
| e de                                  | Examiner  |                     |  | Athero Seler   | which or it                      | Carrelio  | vacintar                                   | - Dise                           | ace   | e Years                                      |  |  |
|                                       | P #   | Iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | Due to (or as a consequ  | uence of):                       |   |  |                                  |   |  |  |  |
| ,<br>0,                               | icate be executed<br>physicien and<br>s the burial-transit  | Examin              | Cause (Disease or injury that initiated events resulting in death) Last  | cDue to (or as a consequ   | uence of):                       |   |  |                                  |   |  |  |  |
| 8760,                                 | physic<br>the b   | dlcal               | •  | d  |                                  |   |  |                                  |   |  |  |  |
| .O. Box 6                             | death certii<br>e attending<br>id for use a   | Physiclan/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown  | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown | death 3                          | Ectopic pregnancy Other (specify)                   |  |                                  | 23d. Date of d<br>Month                         | elivery<br>Day Year                          |  |  |
| <u>a</u>                              | sign<br>d be  | by                  | Part II. Other significant conditions of   | pontributing to death but not resi   | ulting in the ur                 | nderlying cause give                                | en in Part I.                              | 23e. Did to                      |   | to the cause of death?  Probably 4 Donknown  |  |  |
| Vital Records,                        | The<br>ate h<br>page  | Completed           | , ·  |  |                                  |   |  |                                  | an 24b. Were a prior to death? 2 No 1 Ye        |  |  |  |
| Vita                                  | Physicien: Th<br>this certificate<br>ral director, pag  | Be                  | 25. Was case referred to medical examiner?   | Hospital:  | /                                | Othy  | 26. Place of Deat                          | h (Check only o                  | ne)   |  |  |  |
|                                       | S D   | : To                | 1 ☐ Yes 2 ☑ No 27. Manner of Death   | 28a. Date of Injury  | ER/Outpatien<br>28b. Time of     | 28c. Injun  | / at                                       |                                  | lence 6 Other (Sp                               | pecify)                                      |  |  |
| ion                                   | Attending I<br>r death.<br>ector: After<br>by the funer   | atlor               | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Day Year)  | Injury                           | Work  | k?<br>Yes 2 □ No                           |                                  | . ,   |  |  |  |
| Division of                           | el or Atte<br>s after de<br>il Directo  | Certification:      | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At he building, etc. (Specify   | ome, farm, str                   | eet, factory, office                                |  | 28f. Location (S<br>City or Tow  | Street and Number or I<br>n, State)             | Rural Route Number,                          |  |  |
|                                       | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral   | edical (            | 29a. Certifier 12 Certifying Ph<br>(Check only one) 2 Medical Exam   | ysicien: To the best of my kno<br>niner: On the basis of examina<br>and manner stated.         | wledge, death<br>tion and/or inv | occurred at the time<br>restigation, in my op       | ne, date and place,<br>pinion, death occur | and due to the ored at the time, | cause(s) and manner a<br>date and place, and di | as stated.<br>ue to the cause(s)             |  |  |
|                                       | To t<br>To tl   | Ž                   | 29b. Signature and title of certifier  | 1  |                                  | 29c. License  | number                                     | -                                | 29d. Date signed (Moi                           | nth, Day, Year)                              |  |  |
| )                                     | c.  |                     | Manual / K   |  |                                  | 1158  | 543  | 1                                | IECEMBER "                                      | 1, 6005                                      |  |  |
|                                       | 7   |                     |  | completed cause of death (Item   | 123a) (Type,                     | Print) PUN AVE                                      | NUE E                                      | BATIMO                           | RE MAR  | 1229<br>(LANY)                               |  |  |
| · · · · · · · · · · · · · · · · · · · | Sta<br>Registi  |                     | 31. Date filed (Month, Day, Year) DEC 2 9 2005   | 32. Registrar's Signa  | ITUP9                            | E .   |  |                                  |   |  |  |  |

|                  |   |                                     | State of Maryland / Department of Health and I  1- For State Registrar  Certificate of Death   |  | piene 05 42038  |
|------------------|---|-------------------------------------|--|--|---|
|                  | Physici<br>/Medio<br>Examin   | al                                  | 1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution give street and number)  4b. City, Town, or Location of Death  County of the | 2. Date of Dea<br>Month<br>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | Day Year 3. Time of Death 540 c. M  4c. County of Death  Baltimore County   |
|                  | Funeral<br>Director   |                                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.  Usual Residence of Decedent   | 8. Date of Birth<br>(Month, Day                                  |   |
| /land 21215-0036 | uid be filed within 72 hours after death with the Maryland<br>Mental Hyglene.<br>rked other then "natural", or Itams 23s or 28s-f show<br>tite event, the Madical Examerating the rivilitied at | To Be Completed by Funeral Director | 10a. State  Maryland  Baltimore Co.  Towson  10e. Street and Number  7700 York Road  12 Was Decedent Ever in U.S. Armed Forces?  1 ∑Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  9th  10c. City, Town or Location  Towson  10f. Zip Code  21204  13. Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 ∑No 1 □ Yes 2 ∑No Specify:  15. Decedent's Education (Give kind of work done during most of work  | pecify Yes or No-<br>to Rican, etc.)                             | 10d. Inside City Limits  1 Yes 2 X0  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: white  16b. Kind of Business/Industry  Construction  Maiden Sumame) |
| Baitimore, Mary  | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If item 27 le marke<br>any injury or other treumatic<br>once.  |                                     | 19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Re. Robert Brooks Brother   2404 Edgewood Avenue   | Baltimo<br>Date<br>28/05   | ore, MD 21234 20c. Location - City or Town, State Catonsville, Maryland   |
| 8/00/s           | Physician /Medical Examiner and the prival-transit  | lical Examiner                      | 2.3 Ent 1. Enter the in ease, or complicit to is that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart fa ure. List only one cruse on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of a lift) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  | c or respiratory arr   | est, Approximate<br>Interval Between<br>Onset and Death   |
| O. BOX 6         | death certifi<br>e attending p<br>ed for use as   | Physician/Med                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 0 Unknown  23c. If yes, outcome of pregnancy 1  Live birth 2  Fetal death 3  Ectopic pregnancy 4  Pregnant at time of death 5 Other (specify)  |  | 23d. Date of delivery<br>Month Day Year   |
| ds, L            | requires that the de<br>een signed by the a<br>nould be detached f  | by                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tol   | bacco use contribute to the cause of death? es 2 \( \subseteq \text{No} \) 3 \( \subseteq \text{Probably} \) 4 \( \subseteq \frac{4}{2} \subseteq \text{Mnown} \)                                     |
| Vital Records    | The law<br>ate has b<br>page 2 sl   | Completed                           | Anemia   | 24a. Was a<br>autops<br>perforn<br>1 □ Yes                       | sy prior to completion of cause of  |
| DIVISION OT VIT  | tending Phye<br>leath.<br>tor; After this<br>the funeral dir  | Certification; To Be                | Paraminer?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing H  27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined  28a. Date of Injury (Month, Day Year)  (Month, Day Year)  28b. Time of Injury at Work? 1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office  | 28d. Describe ho   | ence 6 Other (Specify) ow injury occurred  treet and Number or Rural Route Number,  |
| בֿ               | To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by  | Medical Cert                        | 29a. Certifier (Check only one)  2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.  29b. Signature and Ultion certifier  29c. License number  | o, and due to the carred at the time, d                          | ause(s) and manner as stated.  ate and place, and due to the cause(s)  9d. Date signed (Month, Day, Year)   |
|                  | 5   |                                     | 30. Name and address of person who completed cause of death-(Item 23a) (Type, Print) Raven RI  | , Bc   | of some of the sister   |
|                  | Sta<br>Registr  | à.                                  | 31. Date filed (Month, Day, Year) DEC 2 9 2005  Ageistrar's Signature  | 1  |   |

|  |   |                     | For State   |   | aryland / De   | epartment of h   | Health and M                       | ental Hygie                                      | 005                            | 42040  |
|--|---|---------------------|---|---|--|--|------------------------------------|--|--------------------------------|--|
|  |   |                     | Registrar  1. Decedent's Name (First, Middle, Last  | )_  |  | Certificate of   | Dealli                             | Reg.<br>2. Date of Death                         |                                | 3. Time of Death                                     |
|  | * Physici<br>/Medic   |                     |   |   | Moore  | Bailey   |                                    | December   | - 23, 200°                     | 5 3:22P M  |
|  | Examin  | _                   | la gacility Neme (If not institution give<br>Mary land Ge   | street and number)                            | lospital   | Baltim   | or Location of Death               |  | 4c. County of Deat             |  |
| A S                                      | Funeral<br>Director   |                     | 216-84-0218   | x 7. Ag<br>□M 200 F                           | ge (In rs. last birthe                               | Months Davs  | Hours Min.                         | 8. Date of Birth<br>(Month, Day, Ye<br>April 30, | 9. Bin<br>1924 No              | thplace (State or Foreign<br>ountry)<br>Yth Carolina |
|  | arytand<br>ehow   | 7                   | Usual Residence of Decedent  10a. State 10b. County  NAY LAND  NAY  |   | 10c. City, Town o                                    | r Location<br>/timore  |                                    |  |                                | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No               |
|  | within 72 hours after death with the Maryland<br>ene.<br>than *natural', or items 23e or 28e-f ehow<br>Ira Malical Examinat frust be mullisd at   | by Funeral Director | 10e. Street and Number  | 100   | Da   | 10f. Zip Code  | 2.4                                | 10g.   | Citizen of What Co<br>United S | ountry?  |
|  | r death w   | ıneral              | 11. Marital Status  | 12. Was Decedent<br>Armed Forces              | Ever in U.S.   | 13. Was Decedent of If Yes, specify Cub  |                                    |  | 14. Race - Ame<br>Black, Whit  | encan Indian,  |
| -0036                                    | nours afte  | d by Fi             | 1 Never Married 2 15 Marned 3 Widowed 4 Divorced  | 1 ☐ Yes 2 1<br>If Yes, Give<br>Year or Dates: |  | 1 ☐ Yes 2 No   |                                    | 1  | Specify: B                     | lack   |
| 2E                                       | rithin 72 h<br>ne.<br>han "natu   | Completed           | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   | ucation<br>de completed)<br>College (1-4or    | 5.)  | ecedent's Usual Occu<br>Give kind of work done<br>ile. DO NOT use retire<br>DMCS+1C. | during most of worki               | n <i>g</i>                                       | rivate.                        | Residence  |
| (00)<br>and 21                           | be filed<br>ital Hygi<br>d other<br>event, I  | Be                  | 17. Father's Name (First, Middle, Last) Raph H. Wil   | liams   |  | J.110317C  |                                    | (First, Middle, Mai                              | den Sumame)                    |  |
| Maryl                                    | d 2 should the and Ment   | 2                   | 19a. Informant's Name/Relationship (7)  |   |  | Mailing Address (Stree   | .1                                 | al Route Number, C                               | ity or Town, State, .          | zip Code) gland 21214                                |
| O. L.                                    | ages 1 and on to 1 to 1 Heelth : if item 27 or other tr   |                     | 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □   | Removal from State                            | 20b. Place of D                                      | Disposition (Name of crematory or other plane)                                       | ace) Jan.                          | Date -2 200                                      | c. Location - City or          |  |
| Baltim                                   | permit. Pa<br>Departmer<br>Important<br>any injury  |                     | 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licens   |   | MORPET   |  | reas of Racility Williams 11451 Bo |  |                                | ,  |
|  |   |                     | 23a. Part I. Enfer the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final                        | olications that cause<br>one cause on each    | ed the death. Do no                                  | t enter the mode of dy   | ring, such as cardiac o            | or respiratory arrest                            | , reary care                   | Approximate<br>Interval Between<br>Onset and Death   |
|  | Physician<br>/Medical<br>Examiner   |                     | disease or condition resulting in death)  | Due to (or as                                 | s a consequence of                                   | abolic   | riciaosi                           | 2  |                                |  |
| 1  |   | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Que to (or as                              | s a consequence of                                   | riy+1111   | 1100                               |  |                                |  |
| 760, 7                                   | te be executed<br>ysicien and<br>ie burial-transit  |                     | that initiated events<br>resulting in death) Last   |   | s a consequence of                                   | ):   |                                    |  |                                |  |
| 687                                      | rtificate<br>ng phys<br>as the  | Medic               | IF FEMALE:  | d   |  |  |                                    |  |                                |  |
| O. Box                                   | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical   | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  |   | e of pregnancy<br>2  Fetel death<br>at time of death | 3 ☐ Ectopic pregnand 5 ☐ Other (specify)   | су                                 |  | 23d. Date of de<br>Month       | livery<br>Day Year                                   |
| ds, P.O.                                 | w requires that the de<br>sbeen signed by the a<br>should be detached f   | ۵                   | Part If. Other significant conditions of  | ontributing to death                          | but not resulting in                                 | the underlying cause g   | given in Part I.                   | 23e. Did tobac                                   | /                              | o the cause of death?                                |
| Recor                                    | he law req<br>e hes beer<br>ige 2 shou  | Completed           |   |   |  |  |                                    | 24a. Was an<br>autopsy<br>performe               | d? prior to death?             | utopsy findings available<br>completion of cause of  |
| /ital                                    | cian: T<br>ertificeta<br>ector, pa  | Be Co               | 25. Was case referred to medical examiner?  |   |  |  |                                    | 1 Yes 2 1 (Check only one)                       | No IL Tes                      | s 2 No   |
| of                                       | g Physic<br>er this coneral dire  | P                   | 1 Yes 2 No 27. Manner of Death  | Hospital: 1 Inpat  28a. Date of Inj (Month, D |  | atient 3 DOA   |                                    | me 5 Residence<br>28d. Describe how              |                                | +cify)   |
| Division of Vital Records,               | To the Hospital or Attending Physicien: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | Certification:      | 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                                       | 28e. Place of Ir                              |  |  | □Yes 2□No                          | 28f. Location (Stre<br>City or Town,             |                                | lural Route Number,                                  |
| Ω  | lospital o<br>hours aff<br>uneral Di  |                     |   |   |  | death occurred at the for investigation, in my                                       |                                    |  |                                |  |
|  | To the H<br>within 24<br>To the F<br>complete   | Medical             | one) 29b. Signature and title of certifier  | and manner s                                  | stated.  | 29c. Licer   | nse number                         |  | I. Date signed (Mon            |  |
|  | 2   |                     | 30. Name and address of person who  | WACHU completed gayse of                      |  | ype, Print) //   | . 89                               | 244 D  | combo                          | -23,2005   |
| 3.                                       |   | ate                 | IKenna NWa 31. Date filed (Month, Day, Year)  | chukwi  | trar's Signature                                     | COIKa  | ryland                             | Genera   | îl HUSPi                       | ta/  |
| 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1 | Regist  |                     | DEC 2 9 2005  | See Lee                                       | M. A   | med  | *                                  |  |                                |  |

DHMH 17 Rev 1/2001

ORIGINAL

|            |   |                     | 1 - For State Registrar  |   | Marylar   |                                   | artmen<br>rtificat                 |                     |                                      |                       | Mental Hy                            | Reg. No.                 | 05                          | 420                                   |                       |
|------------|---|---------------------|--|---|---|-----------------------------------|------------------------------------|---------------------|--------------------------------------|-----------------------|--------------------------------------|--------------------------|-----------------------------|---------------------------------------|-----------------------|
| 18.<br>18. | Physici   | an                  | 1. Decedent's Name (First, Middle, I<br>Urban Patrick Boy  |   |   |                                   |                                    |                     |                                      |                       | 2. Date of Do<br>Month               | Day                      | Year                        |                                       |                       |
|            | /Medic<br>Examin  |                     | 4a. Facility Name (If not institution, g   |   | ber)  |                                   | 4b. City,                          | Town, or            | Location of                          | of Death              | Decemb                               |                          | 4 200 County of Dea         | )                                     | , 1                   |
| 45         | Exami   | lei                 | Stella Maris Hos   |   |   |                                   |                                    | oniu                |                                      |                       |                                      |                          | altimo                      |                                       |                       |
| 21.<br>13  | Funeral<br>Director   |                     |  |   | 7. Age (In yrs.   | last birthday)<br>Yrs.            | If Under<br>Months                 | 1 Year<br>Days      | If Under<br>Hours                    | 24 Hrs.<br>Min.       | 8. Date of Bi<br>(Month, D<br>May 11 | rth<br>ay, Year)<br>192  | - (                         | rthplace (State<br>country)<br>ryland | or Foreign            |
|            | put   |                     | Usual Residence of Decedent 10a. State 10b. County   |   | 10c C   | ity, Town or Lo                   | ocation                            |                     |                                      |                       |                                      |                          |                             | 10d. Inside (                         | City Limite           |
|            | Maryli<br>-1 eho  | tōr                 | Maryland Baltimo   | ore   |   | 1timor                            |                                    |                     |                                      |                       |                                      |                          |                             |                                       | s 2 X No              |
|            | th the  | Jirec               | 10e. Street and Number   |   |   |                                   | 10f. Zip                           | Code                |                                      |                       |                                      | 10g. Citiz               | en of What C                | ountry?                               |                       |
|            | ath w   | rai                 | 1252 Halstead Rd.  |   |   |                                   |                                    | 234                 |                                      |                       |                                      |                          | ed Sta                      |                                       |                       |
| 39         | 2 should be filed within 72 hours after death with the Maryland and Mental Hygene. In marked other than "natural", or items 23s or 28s-1 ehow aumatic event, the Medical Exam per must be notified at | by Funeral Director | 11. Marital Status  1 □ Never Married 2∑ Married 3 □ Widowed 4 □ Divorced  | IF Vac Cive   | ces?  |                                   | Was Dece<br>If Yes, spe<br>1 ☐ Yes |                     | spanic Ori<br>n, Mexicar<br>Specify: | gin? (Sp<br>n, Puerto | ecity Yes or N<br>Rican, etc.)       |                          | Black, Whi                  | erican Indian,<br>ite, etc.<br>white  |                       |
| Š          | 2 hou   | ted                 | 15. Decedent's   | Education   | I J <del>-1</del> U   | 16a. Dece                         | dent's Usu                         |                     |                                      | A = 6= ale            | ·                                    | 16b. Kin                 | d of Business               | s/Industry                            |                       |
| 21215-0036 | vithin 7  | Completed           | (Specify only highest of Elementary/Secondary (0-12)   | College (1-   | 4or 5+)   | life.                             | kind of wo<br>DO NOT u             | se retired          | )                                    | LOI WOIK              | ing                                  | nh                       | /-                          |                                       | stor                  |
| 2          | filed v<br>Hygie<br>other t   | ပိ                  | 17. Father's Name (First, Middle, La   | 4<br>st)  |   | man                               | ager                               |                     | 18. Mothe                            | er's Nam              | e (First, Middle                     |                          |                             | onvenie                               | ence                  |
| an         | 0 = 0 >   | To Be               | Urban Francis  | Bowe  | S   |                                   |                                    |                     |                                      |                       | Rosalba                              |                          |                             |                                       |                       |
| Maryland   | d 2 should<br>h and Men<br>7 ie marke<br>traumatic  |                     | 19a. Informant's Name/Relationship Rosalie Bowes/wii   |   |   |                                   | ng Address<br>2 Hal                |                     |                                      |                       | al Route Numb<br>Baltimo             |                          |                             |                                       |                       |
|            | s 1 and<br>f Health<br>item 27<br>other tr  |                     | 20a. Method of Disposition   | LE .  | 20b.  | Place of Dispo                    |                                    |                     |                                      |                       | Date                                 |                          |                             | Town, State                           |                       |
| Ë          | Pages<br>nent of<br>int: if it<br>ury or o  |                     | 1 ☐ Burial 2 XX Cremation 3<br>4 ☐ Donation 5 ☐ Other (Specific Control of Cont |   |   |                                   |                                    |                     |                                      | ec. 2                 | 28,2005                              | Ba1                      | timore                      | , Mary                                | land                  |
| Baltimore, | permit. Pages 1 and 2 should b<br>Department of thealth and Menta<br>Important: If Item 27 is marked<br>eny injury or other traumatic e<br>once.  |                     | 21. Signature of Funeral Service Lic   | ensee<br>Nell   |   | 22                                | Name ar<br>Mi<br>65                | tche                | s of Facilit<br>11-Wi<br>ork R       | edef                  | Teld Fu<br>Balti                     | neral<br>more,           | Home,                       | Inc.<br>1212                          |                       |
| 8)<br>In   | Physician   |                     | 23a Anti. Enter the disease, or co<br>chock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition   | ly one cause on ea                                      | ch line.  | th. Do not ent                    | ter the mod                        | le of dying         | g, such as                           | cardiac               | or respiratory a                     | rrest,                   |                             | Approxima<br>Interval Be<br>Onset and | etween                |
| , %        | The law requires that the death certificate be executed was the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit                                | edicai Examiner     | Sequentially list conditions, Lay, cache immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. — Due to (c  | or as a consecutive as | quence of):                       |                                    |                     |                                      |                       |                                      |                          |                             |                                       |                       |
| O. Box     | at the death certific<br>by the attending p<br>tached for use as I  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |   | th 2 ∏ Feta<br>nt at time of o  | aldeath 3[                        | ]Ectopic pr<br>] Other (sp         | regnancy<br>pecify) |                                      |                       |                                      | 23                       | 3d. Date of de<br>Month     | livery<br>Day                         | Year                  |
| ds, P      | uires that<br>signed by<br>Id be deta   | by                  | Part II. Other significant conditions  | contributing to dea                                     | ath but not res   | sulting in the u                  | nderlying c                        | ause give           | n in Part I.                         |                       |                                      |                          |                             | o the cause of                        |                       |
| Records,   | : The faw require<br>cate has been si<br>; page 2 should t  | Completed           |  |   |   |                                   |                                    |                     |                                      |                       |                                      | psy<br>ormed?            | prior to death?             | utopsy findings<br>completion of      | available<br>cause of |
|            |   | BeC                 | 25. Was case referred to medical examiner?   |   |   |                                   |                                    |                     | 26. Place                            | of Deati              | 1 Yes                                |                          | 1 L Yes                     | 2 □ No                                |                       |
| ><br>5     | Physic<br>this ce<br>al dire  | 유                   | 1 ☐ Yes 2 X No   | -   |   | ER/Outpatier                      |                                    |                     | 4 🗀 INU                              |                       |                                      |                          |                             | ecify) HOSI                           | PICE                  |
| 00         | ding f  | tion:               | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigat   | 28a. Date of<br>(Month                                  | njury<br>, Day Year)  | 28b. Time o<br>Injury             | f 2<br>M                           | 8c. Injury<br>Work  | at<br>:?<br>∕es 2 ∐ l                | i                     | 28d. Describe                        | how injury               | occurred                    |                                       |                       |
| DIVISION   | in the o  | Certification:      | 2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine   | be 28e. Place   | of Injury - At h<br>g, etc. <i>(Speci</i>   | nome, farm, str<br>fy)            |                                    |                     |                                      | -                     |                                      | Street and<br>wn, State) | Number or R                 | ural Route Nur                        | mber,                 |
|            | To the Hospital within 24 hours a To the Funeral I completely filled  | edical C            | 29a. Certifier (Check only one)  Certifying 1 Certifying 2 Medical Ex  | Physician: To the la<br>aminer: On the ba-<br>and manne |   | owledge, deatl<br>ation and/or in | h occurred<br>vestigation          | at the tim          | e, date an<br>inion, dea             | d place,<br>th occurr | and due to the<br>ed at the time,    | cause(s) a<br>date and p | nd manner a<br>lace, and du | s stated.<br>e to the cause(          | s)                    |
|            | To the within 2 To the complet  | M                   | 29b. Signature and little of certifier   |   |   |                                   | 1                                  | . License           |                                      |                       |                                      | 29d. Date                | signed (Mon                 | th, Day, Year)                        |                       |
|            | 1   |                     |  | 12-   |   |                                   | 1                                  | ) 43                | 725                                  | _                     |                                      | 121                      | 127/0                       | 5                                     |                       |
|            | (:)   |                     | 30. Name and address of person wh  |   |   |                                   |                                    |                     | m <b>*</b> * * * * * *               | ****                  |                                      | 005                      |                             |                                       |                       |
| 200        | Sta   | te                  | DR. TARIQ MAHM 31. Date filed (Month, Day, Year)   | . 34 Re   | gistrar's Sign  | NEY VAL                           |                                    | Ψ.                  | TTMON                                | NI UM.                | MD 21                                | 093                      |                             |                                       |                       |
| 17         | Registr   | ar                  | DEC 2 9 20   | 05  | 10 . A  | 1 the                             | K)                                 |                     |                                      |                       |                                      |                          |                             |                                       |                       |

DHMH 17 Rev 1/2001

DECEMBER 24, 2005 /:55 p.m.

URBAN BOWES

|  |  |                  | for<br>State<br>Registrar   | State of Maryl   | and / Dep                            |   | Health and M   | lental Hyg                                 |   | 42042  |
|--|--|------------------|---|--|--------------------------------------|---|--|--|---|--|
|  | Physic   |                  | 1. Decedent's Name <i>(First, Middl</i> e,<br>Arthur J  | Coseph Carter,   | Jr.                                  |   |  | 2. Date of Dea<br>Month<br>DECEMB          | Day Yea                                     | 4.4  |
|  | /Medi<br>Exami   |                  | 4a. Facility Name (If not institution,  |  |                                      | 4b. City, Town, o   | or Location of Death                                     |  | 4c. County of D                             | 1.00 41  |
|  |  |                  | GREATER BALTIMO   | RE MEDICAL CEN   | TER                                  | TOWSO   | N  |  | BALTIM                                      | ORE  |
|  | Funeral<br>Director  |                  | 215-28-5271   | . Sex 7. Age (In) 17 M 2□F 75  | vrs. last birthday,<br>Yrs.          |   | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth<br>(Month, Day<br>Nov. 27 | (Year) 9.1                                  | Birthplace (State or Foreign<br>Country)<br>[aryland |
|  | Du ≱ _   |                  | Usual Residence of Decedent  10a. State 10b. County   | 100  | City, Town or L                      | ocation   |  |  |   |  |
|  | ceam with the Maryland<br>ms 23a or 28a-f ehow<br>Limital be notified at                                 | ector            | Md. Baltim  |  | Reister                              |   |  |  |   | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No               |
|  | 23a or 2   | Funeral Director | 10e. Street and Number<br>12814 Dov   | er Road  |                                      | 10f. Zip Code 21]   | 136  | 1  | 0g. Citizen of What U.S.                    |  |
| 3  | within /z mouts after dea<br>ene.<br>then "natural", or items<br>the Medical Examinal ma                 | b                | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 1634 01  | 951-                                 | Was Decedent of H<br>If Yes, specify Cubin                    | dispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)           | 14. Race - Al<br>Black, W<br>Specify: W     |  |
| Maryland 21215-0036  | inatu<br>inatu   | Completed        | 15. Decedent's (Specify only highest statementary/Secondary (0-12)  | Education<br>grade completed)<br>College (1-4or 5+)  | 16a. Dece<br>(Give<br>life.          | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | pation<br>during most of works<br>d)                     | ng   | 16b. Kind of Busine                         | ,  |
| 21   | al Hygiene. I other then '   | Con              | 12  | 4  | Br                                   | oadcast E   | Engineer   |  | Televi                                      | sion   |
| Pin 3  | 9 5 5 6  | Be               | 17. Father's Name (First, Middle, La  | ,  |                                      |   | 18. Mother's Name  |  | -   |  |
| 20   | should be lifed<br>ind Mental Hygi<br>marked other<br>umatic event, I                                    | ပ                |   | . Carter, Sr.  |                                      |   |  | Mae Mul                                    |   |  |
| Mai  |  |                  | 19a. Informant's Name/Relationship Bernice Carter   |  | 19b. Maili                           | ng Address (Street  | and Number or Rura                                       | I Route Number                             | , City or Town, State                       | , Zip Code)  |
| வ் 3   | of Health and Mer<br>item 27 is marks<br>cother traumatic  |                  | 20a. Method of Disposition  |  | D. Place of Dispo                    | DOVET RU  | ., Reiste  |  |   |  |
| Baltimore,   |  |                  | 1 ☐ Burial 2 ☐ Cremation 3  | Permanal from State  | cemetery, crei                       | matory or other plac  | ce)  |  | 20c. Location - City                        |  |
|  | Department of importent: if any injury or once.  |                  | 4 □ Donation 5 □ Other (Special Signature Fune) al Service Lice   | ensee /  |                                      | 2. Name and Address   | dens Dec.  | 30,200                                     | Finksbu                                     |  |
| Ba   | Depa<br>fmpo<br>any i  |                  | 14450   | On St.   | 2                                    | Eckhardt  | Funeral C<br>sterstown                                   | hapel. I                                   | P.A.  | 21117  |
| *  | hysician<br>/Medical   |                  | 23a. Part1. Enter the disease, or co<br>shock, or Heart failure. List on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)         | mplications that caused the dry one cause on each line.  a                                     | sia                                  | er the mode of dyin   | g, such as cardiac o                                     | r respiratory arre                         | vings Mill<br>est,                          | Approximate Interval Between Onset and Death         |
| £ E  | xaminer  | er               | Sequentially list conditions,   | b. Due to (or as a cons  |                                      |   |  |  |   |  |
| 760,   | cien and   | Ä                | Sequentially list conditions, if any, leading to immodate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | c.  Due to (or as a cons   | equence of):                         |   |  |  |   |  |
| - g  | physik<br>the b  | dical            | <b>`</b>  | d  |                                      |   |  |  |   |  |
| Records, P.O. Box 68 The law requires that the death certifica | igned by the attending physicien and be detached for use as the burial-transit                           | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of prec<br>1 □ Live birth 2 □ Fe<br>4 □ Pregnant at time o<br>9 □ Unknown | etal death 3                         | Ectopic pregnancy<br>Other (specify)                          |  |  | 23d. Date of d<br>Month                     | elivery<br>Day Year                                  |
| , D  | ned by<br>e deta   |                  | Part II. Other significant conditions   | contributing to death but not r  | esulting in the u                    | nderlying cause give  | en in Part I.  | 23e. Did tob                               | acco use contribute                         | to the cause of death?                               |
| rds  | been sig<br>should b   | edb              | hung Noch   | ule  |                                      |   |  | 1 □ Ye                                     | s 2 □ No 3 □ F                              | Probably 4 Unknown                                   |
| Records,   | his certificate has be<br>director, page 2 sh  | Completed by     | helt Upper  | hung hote  | lesec                                | tion  |  | 24a. Was an autopsy perform                | prior to<br>ded? death?                     |  |
| Vital  | ntifica<br>ctor, I   | Be C             | 25. Was case referred to medical  |  |                                      |   | 26. Place of Death                                       |  | No 1□Ye                                     | s 2 No   |
| Of V   | this ce<br>al dire   | To I             | examiner?<br>1 ☐ Yes 2 X No   | Hospital: 1 Inpatient 2  | ☐ ER/Outpatien                       | t 3 DOA Othe  |  |  | nce 6 □Other (Sp                            | ecify)   |
| Division o   | ath.<br>or: After th   |                  | 27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigate   |  | 28b. Time of<br>Injury               | 28c. Injury<br>Work<br>M 1                                    |  |  | w injury occurred                           | outy   |
| Division   | 24 hours after death<br>Funerel Director: A<br>stely filled in by the t                                  | Certification:   | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   |  | home, farm, stre<br>cify)            | eet, factory, office  | 2  | 8f. Location (Stre<br>City or Town,        | eet and Number or F<br>State)               | Rural Route Number,                                  |
| Division of Vita   | within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral | Medical          | 29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa  | Physician: To the best of my k<br>iminer: On the basis of exami<br>and manner stated.          | nowledge, death<br>nation and/or inv | occurred at the tim<br>restigation, in my op                  | e, date and place, a<br>pinion, death occurre            | nd due to the car<br>d at the time, da     | use(s) and manner a<br>te and place, and du | as stated.<br>le to the cause(s)                     |
| Tot  | within<br>To the<br>comple   | Σ                | 29b. Signature and title of certifier   |  |                                      | 29c. License  | number   | 29   | d. Date signed (Mor                         | nth, Day, Year)                                      |
|  | 7  |                  | 1/11.6/2  | N MI)  |                                      | D00   | 59474  |  | 12/27/0                                     | 5  |
| 10   |  |                  | 30. Name and address of person was  | 2 6701 1   | DECTH                                |   | 55 BM  | TMORE                                      | maryem                                      | 0 2/204  |
|  | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)   | 2005   | nature                               | and a   |  | 7  |   |  |

|                |   | _              | For<br>State<br>Registrar  | State of N  | aryland                |                                       | artment<br><i>tificate</i> |                             |                            | and M                   |                                     | 200                              | 5 L                        | 204  | 3                  |
|----------------|---|----------------|--|---|------------------------|---------------------------------------|----------------------------|-----------------------------|----------------------------|-------------------------|-------------------------------------|----------------------------------|----------------------------|--|--------------------|
|                |   |                | Registrar  1. Decedent's Name (First, Middle, and American State of the Company o | Last)   |                        | 001                                   | incate                     | , OI L                      | Catin                      | 1                       | 2. Date of Dea                      | th                               |                            | 3. Time of E                                 | Death              |
|                | Physici<br>/Medic   | an<br>al       | Finis G. Combs   | 5   | r)                     |                                       | 4b. City. T                | own, or                     | Location o                 | of Death                | December 1                          |                                  | Year<br>2005<br>y of Death | 6:00   | am <sup>M</sup>    |
|                | Examin  | er             | Hart Heritage As   |   |                        |                                       | Stre                       |                             |                            |                         |                                     | Harf                             |                            |  |                    |
| Н              | Funeral   |                |  | . Sex 7. A  | ge (In yrs. las        | t birthday)                           | If Under                   |                             | If Under                   | 24 Hrs.<br>Min.         | 8. Date of Birth<br>(Month, Day     |                                  |                            | place (State or                              | Foreign            |
|                | Director  |                | 414-14-3140  | 1ÅM 2□F   | 93                     | Yrs.                                  | WOTUTS                     | Days                        | 110013                     |                         | Aug 17                              |                                  |                            | nessee                                       |                    |
|                | and   | -              | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, 1           | Town or Lo                            | cation                     |                             |                            |                         |                                     |                                  |                            | 10d. Inside City                             | / Limits           |
|                | f sho   | ğ              | Maryland Harfor  | ~ <del>.</del>  | Fore                   | st Hi                                 | 11                         |                             |                            |                         |                                     |                                  |                            | 1 ☐ Yes                                      | 2 <b>X</b> No      |
|                | r 28e   | Director       | 10e. Street and Number   | <u>.u</u>   | TOLE                   | SC 111                                | 10f. Zip                   | Code                        |                            |                         |                                     | l0g. Citizen of                  | What Cou                   | ntry?  |                    |
|                | h with  |                | 2554 Chestnut Hi   | 11 Road   |                        |                                       | 210                        | 50                          |                            |                         |                                     | U.S.                             | Α                          |  |                    |
|                | ems<br>erru   | Funerai        | 11. Marital Status   | 12. Was Deceder<br>Armed Force                              | s?                     | 13. \                                 | Was Decede<br>f Yes, speci | ent of His                  | spanic Ori                 | gin? (Spe<br>, Puerto   | ecify Yes or No-<br>Rican, etc.)    |                                  | ce - Ameri<br>ck, White,   |  |                    |
| 36             | s afte  | by Fu          | 1 ☐ Never Married 2 ☐ Married<br>3 ☑ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ☐<br>If Yes, Give<br>Year or Dates                | _                      |                                       | 1 ☐ Yes 2                  | <b>№</b> No                 | Specify:                   |                         |                                     | Speci                            |                            | <b>+</b> -                                   |                    |
| 21215-0036     | d within 72 hours after death with the Maryland<br>jiene.<br>r than "natural", or tlems 23a or 28e-f show<br>the Madical Evandract coust be notified at | edt            | 15. Decedent's   | Education   |                        | 16a. Deced                            | ient's Usual               | Occupa                      | tion                       |                         |                                     | 16b. Kind of E                   | Whj<br>Business/Ir         |  |                    |
| 215            | within 72<br>ene.<br>than "na   | Completed      | (Specify only highest<br>Elementary/Secondary (0-12)   | grade completed) College (1-4c                              | or 5+)                 | (Give<br>life. I                      | kind of worl<br>DO NOT use | k done d<br>e retired)      | uring mosi                 | t of worki              | ng                                  |                                  |                            |  |                    |
|                | filed wit<br>Hygiene<br>other the   | Com            | 9  |   |                        | Fabri                                 | cator                      |                             |                            |                         |                                     | Aero -                           | _                          | re   |                    |
| n<br>D         | S E S   | Be             | 17. Father's Name (First, Middle, La   | ist)  |                        |                                       |                            |                             |                            | _                       | (First, Middle,                     | Maiden Suma                      | me)                        |  |                    |
| Maryland       | d 2 should Ith and Meni7 is markettraumatic   | ဥ              | Twilight Combs  19a. Informant's Name/Relationship   | (Type Print)  |                        | 19h Mailir                            | a Address                  | (Street a                   | Pea:                       |                         | Glenn<br>al Route Numbe             | r. City or Town                  | State. Ziu                 | Code)  |                    |
| N<br>N         | 12<br>ha<br>7 is  |                | Russell Combs  |   |                        |                                       | Ches                       |                             |                            |                         |                                     |                                  |                            | 21050  |                    |
|                | s 1 and<br>if Healt<br>item 2<br>other  | 1              | 20a. Method of Disposition   |   | cen                    | ce of Dispo                           | sition (Nam                | e of                        | -                          |                         | Date                                | 20c. Location                    |                            |  |                    |
| e<br>E         |   |                | 1 Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (58)  |   | te .                   | -                                     | .1 Cem                     |                             | 1                          | 12/                     |                                     | Brook                            | lvn.                       | Maryla                                       | nd                 |
| Baltimore,     | 그런런 한다.   |                | 21 Signature of Funeral Service Ci   | //  | C                      | 22                                    | . Name and                 | Addres                      | s of Facilit               | ty                      |                                     |                                  |                            |  |                    |
| 0              | Depa<br>Impo<br>any ii  | 4              | Jenuse f   | my ly   |                        |                                       |                            |                             |                            |                         | l Home !<br>venue !                 | Essex,                           | Mary]                      | and 21                                       | 221                |
| н              |   |                | 23a. Part 1. Enter the disease, or c<br>shock, or heart failure. List of   | omplications that caus<br>ily one cause on each             | ed the death.<br>line. | Do not ent                            | er the mode                | of dying                    | g, such as                 | cardiac o               | or respiratory ar                   | rest,                            |                            | Approximate<br>Interval Betw<br>Onset and Do | reen               |
| -              | Physician   | 0.0            | Immediate Cause (Final disease or condition resulting in death)  | a. End  | Stag                   | 10                                    | Deme                       | ntie                        | 2                          |                         |                                     |                                  | į.                         | year   | 5                  |
|                | /Medical<br>Examiner  |                | resulting in death)  | Due to (or  | as a conseque          | nce of):                              |                            |                             |                            |                         |                                     |                                  |                            |  |                    |
|                |   | F              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | b. Due to (or a   | as a conseque          | nce of):                              |                            |                             |                            |                         |                                     |                                  |                            |  |                    |
| /              | uted<br>d<br>ansit  | Examiner       | Cause (Disease or injury that initiated events   | C   |                        |                                       |                            |                             |                            |                         |                                     |                                  |                            |  |                    |
| o,             | be executed<br>sician and<br>burial-transit   |                | resulting in death) Last   |   | as a conseque          | nce of):                              |                            |                             |                            | _                       |                                     |                                  |                            |  |                    |
| 3760,          | \$ × ×  | licai          | <b>'</b>   | d   |                        | · · · · · · · · · · · · · · · · · · · |                            |                             |                            |                         |                                     |                                  |                            |  |                    |
| x 68           | The law requires that the death certificat<br>ite has been signed by the attending phy<br>page 2 should be detached for use as th                       | Physician/Med  | IF FEMALE:   | 23c. If yes, outcor   | ne of pregnanc         | ~v                                    |                            |                             |                            |                         |                                     | 224 D                            | ate of deliv               | 00/  |                    |
| Вох            | attenc<br>attenc<br>for us  | ian            | 23b. Was decedent pregnant in the past 12 months?  | 1 Live birth  | 2 Fetal d              | eath 3[                               | Ectopic pre                |                             |                            |                         |                                     |                                  | onth                       |  | ear                |
| o.             | at the de<br>by the   | ysic           | 1 Yes 2 No   | 9☐ Unknown  |                        |                                       |                            |                             |                            |                         |                                     |                                  |                            |  |                    |
| α.             | s that<br>ned b<br>e deta   | by Pł          | Part II. Other significant condition   | s contributing to death                                     | but not resulti        | ing in the u                          | nderlying ca               | ause give                   | n in Part I                |                         | 23e. Did to                         | bacco use cor                    | ntribute to                | he cause of de                               |                    |
| rds            | w requires<br>been sign<br>should be  | ed b           |  |   |                        |                                       |                            |                             |                            |                         | 1 🗆 Y                               | es 2 No                          | 3 🗆 Pro                    | bably 4, ⊠Ur                                 | nknown             |
| Vital Records, | e law requ<br>has been<br>ye 2 shoul  | Completed      |  |   |                        |                                       |                            |                             |                            |                         | 24a. Was autop                      | sy                               | prior to co                | opsy findings a<br>impletion of ca           | vailable<br>use of |
| <u>m</u>       |   | E O            |  |   |                        |                                       |                            |                             |                            |                         | perför<br>1 ☐ Yes                   | med?<br>2X No                    | death?<br>1 ☐ Yes          | 2□ No  |                    |
| /ita           | E E   | Be             | 25. Was case referred to medical examiner?   | Hospital:   |                        |                                       | -                          | Othe                        |                            |                         | (Check only o                       |                                  |                            | Assis  | ted                |
| of             | dis ys  | 2              | 1 ☐ Yes 2X No 27. Manner of Death  | 1 🗆 Inpa  |                        | R/Outpatier<br>8b. Time o             | -                          | A                           | 4 🗆 NU                     |                         | me 5 🗆 Resid<br>28d. Describe h     |                                  |                            | w Livin                                      | J                  |
| Ö              | ding<br>h.<br>After<br>fune   | tion           | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investiga  |   | Day Year)              | Injury                                | М                          | 8c. Injury<br>Work<br>1 🗆 ` | ດ?ົ<br>Yes 2.∐             | No                      |                                     |                                  |                            |  |                    |
| Division       | or Attendiater death. Director: A   | ifica          | 3 Suicide 6 Could no   | ot be 28e. Place of   | Injury - At hom        | e, farm, st                           | reet, factory              | , office                    |                            |                         | 28f. Location (5<br>City or Tow     |                                  | ber or Rur                 | al Route Numb                                | er,                |
| ā              | s after<br>el Direct  | Certification: | 4   Homicide   | Building,   | etc. (Specify)         |                                       |                            |                             |                            |                         | 0.9 0.7 0                           |                                  |                            |  |                    |
|                | To the Hospital or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune                               | Medical        | 29a. Certifier 1 Certifying (Check only one) 2 Medical E   | Physician: To the be<br>xaminer: On the basis<br>and manner | s of examinatio        | ledge, deat<br>on and/or in           | h occurred a vestigation,  | at the tim<br>in my op      | ne, date ar<br>pinion, dea | nd place,<br>ath occurr | and due to the ored at the time, or | cause(s) and n<br>date and place | nanner as :<br>, and due ! | stated.<br>to the cause(s)                   |                    |
|                | To th<br>within<br>To th<br>comp  | Me             | 29b. Signature and title of certifier  | p An  | MO                     |                                       |                            |                             | number<br>988              | ,9                      |                                     | 29d. Date sign                   |                            | Day, Year)                                   |                    |
| 7              | 01  |                | 30. Name and address of person w   | nho completed cause of                                      | of death (Item 2       | 23a) (Type,                           | D-:-+)                     |                             |                            |                         |                                     |                                  | 2/0/2                      |  |                    |
|                | 1   |                | Alfred Sp.   | ATKS GI   |                        |                                       | ac Ph                      | 911                         | Be                         | 0/ /4                   | ir M                                |                                  | 2/014                      | <i>f</i>                                     |                    |
|                |   | ate            | 31. Date filed (Month, Day, Year)  | 32. Reg   | istrar's Signatu       | re                                    |                            |                             |                            |                         |                                     |                                  |                            |  |                    |
|                | Regist  | rai            | DEC 2 9 2005   | Marie .   | to do                  | 246 1                                 |                            |                             |                            |                         |                                     |                                  |                            |  |                    |

|                            |   |                | T = For State Registrar  | State of M   | laryland / I                | Departm<br><i>Certific</i>        |                        |                             | nd Mental H                                 | ygiene<br>Reg. No. | 05                                     | 42044                                |
|----------------------------|---|----------------|--|--|-----------------------------|-----------------------------------|------------------------|-----------------------------|---|--------------------|--|--------------------------------------|
|                            | Physic  |                | 1. Decedent's Name (First, Middle The Mac  | e, Last)   |                             |                                   |                        |                             | 2. Date of D<br>Month                       | eath<br>Day        | Yeer                                   | 3. Time of Death                     |
|                            | /Medi<br>Exami  |                | 4a. Facility Name (If not institution  | n, give street and number  | -)                          | 4b. C                             | ity, Town, o           | Location of                 | Death                                       | 46. C              | ounty of Dea                           |                                      |
|                            | A;  |                | Northway 1   | Torrital   |                             | 13                                | and al                 | Inton                       | n   | B                  | 2/2:0                                  | 0 h 0                                |
|                            | Funeral<br>Director   |                | 5. Social Security Number 236-56-6270  | 1 G. Seex 7. A   | ge (In yrs. last bii<br>6 0 | thday) If Ur<br>Yrs. Mont         | der 1 Year<br>hs Days  | If Under 24<br>Hours        | Hrs. 8. Date of B<br>Min. (Month, D         | irth<br>ay, Year)  | 9. Bir                                 | thptace (State or Foreign<br>buntry) |
|                            |   |                | Usual Residence of Decedent  |  | 68                          | 113.                              |                        |                             | Nov. 2                                      | 3,1937             |  | WV                                   |
|                            | rylan   | L              | 10a. State 10b. County   |  | 10c. City, Tow              | n or Location                     |                        |                             |   |                    |  | 10d. Inside City Limits              |
|                            | Ba-1 e  | Director       | MD Balti   | more   | Rei                         | sterst                            | own                    |                             |   |                    |  | 1 ☐ Yes 2 No                         |
|                            | rurs after death with the Marylan<br>el', or iteme 23a or 28a-1 ehow<br>Exercir at most be motified at  |                | 10e. Street and Number   |  |                             | 10f.                              | Zip Code               |                             |   | 10g. Citize        | n of What Co                           | ountry?                              |
|                            | leath   | Funerai        | 116 Rockrimmon   | 1 Road<br>12. Was Decedent   | Ever in 11 S                | 12 Was Da                         | 211                    |                             | 0.00  |                    | USA                                    |                                      |
| 9                          | or iter   | Fun            | 1 ☐ Never Married 2 € Marr   | Armed Forces<br>ied 1 ☐ Yes 2127   | ?                           |                                   |                        | n, Mexican, F               | n? (Specify Yes or N<br>Puerto Rican, etc.) | 0- 14              | . Race - Ame<br>Black, Whit            |                                      |
| 933                        | ours a  | d by           | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give Year or Dates:  |                             | 1 TYes                            | 2 <b>∑</b> No          | Specify:                    |   | Si                 | pecify:                                | White                                |
| 5-(                        | within 72 hours after death with the Maryland<br>jiene "naturel", or iteme 23a or 28a-1 ehow<br>the Medical Exertir at must be notified at                          | Completed      | 15. Decedent<br>(Specify only highes   | t's Education<br>of grade completed)   | 16a.                        | Decedent's U                      | work done o            | lurina most o               | f working                                   | 16b. Kind          | of Business/                           |                                      |
| 12                         | iene.   | dmc            | Elementary/Secondary (0-12)  | College (1-4or   | 5+)                         | life. DO NO                       |                        |                             | · ·   | NT                 |  |                                      |
| d 2                        | Hyge th   | Be Co          | 17. Father's Name (First, Middle,  | Last)  |                             | Recep                             | cionis                 |                             | Name (First, Middle                         |                    | sing H                                 | ome                                  |
| Maryland 21215-0036        | ರ್ಷ ಕ್ಷಾತ್ರಿ  | ToB            | Chester Rainey   | •  |                             |                                   |                        |                             | ice Spence                                  |                    | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                                      |
| lan                        | 2 should<br>and Men<br>is marka<br>aumatic  | ľ              | 19a. Informant's Name/Relationsh   | nip (Type, Print)  | 19b.                        | . Mailing Addr                    | ess (Street a          |                             | or Rural Route Numb                         |                    | own, State, Z                          | Tip Code)                            |
|                            | s 1 and 2 should<br>f Health and Mer<br>Item 27 is merks<br>other traumatic   |                | John W. Chattin  | Husband  | 11                          | 6 Rock                            | cimmon                 | Road,                       | Reisters                                    | town,              | MD 21                                  | 136                                  |
| Baltimore,                 | 0 = 5   |                | 20a. Method of Disposition  1 Surial 2 Cremation   | 3 ☐Removal from State  | cemeter                     | Disposition (f<br>y, crematory o  | r other place          |                             | Date  | 20c. Loca          | tion - City or                         | Town, State                          |
| 턡                          | 교문문증.   |                | 4 ☐ Donation 5 ☐ Other (S <sub>k</sub> 21. Signature of Funeral Service I                                  |  | All S                       | aints (                           | Cemete<br>and Addres   | -                           |   |                    | tersto                                 |                                      |
| Ba                         | Depa<br>impo<br>eny is  |                | Kour B C   | Se Carre   |                             |                                   |                        | s of Facility<br>ral Ho     |   |                    |  | stown Road<br>MD 21136               |
|                            |   | _              | 23a Part1. Enter the disease, or shock, or heart failure. List   | complications that cause   | d the death. Don            |                                   |                        |                             |   |                    | scowii,                                | Approximate                          |
|                            | Physician   |                | Immediate Cause (Final disease or condition  | D he   | - 40 > 6 : 4                |                                   |                        |                             |   |                    |  | Interval Between<br>Onset and Death  |
| 19                         | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as  | a consequence               | of):                              |                        |                             |   |                    |  |                                      |
|                            | - A   | 16             | Sequentially list conditions,  | b. — Due to for the  |                             | 0                                 |                        |                             |   |                    |  |                                      |
| X                          | uted<br>I   | Examiner       | Sequentiatly list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury | District for an  | a consequence o             | wy:                               |                        |                             |   |                    |  |                                      |
| o Î                        | exect<br>an and<br>rial-tra   |                | that initiated events<br>resulting in death) Last  | c. Due to (or as   | a consequence of            | of):                              | _                      |                             |   |                    | -                                      |                                      |
| 8760,                      | The law requires that the death certificate be executed tile has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit | dicai          |  | d  |                             |                                   |                        |                             |   |                    |  |                                      |
| မ                          | entifica<br>ling pl   | Med            | IF FEMALE:   |  |                             |                                   |                        |                             |   |                    | T                                      |                                      |
| Вох                        | eath certifi<br>attending<br>for use as   | lan/           | 23b. Was decedent pregnant in the past 12 months?  |  | 2 Fetal death               | 3 □Ectopic                        |                        |                             |   | 23d                | Date of deliv                          | -                                    |
| P.O.                       | that the deatled by the atte  | Physician/Me   | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown  | 4☐ Pregnant at<br>9☐ Unknown   | time of death               | 5 Other (                         | specify)               |                             |   |                    | Month                                  | Day Year                             |
| <u>ر</u> ر                 | res that<br>igned b<br>be deta  | by Pr          | Part II. Other significant condition   | ns contributing to death b   | ut not resulting in         | the underlying                    | cause give             | n in Part I.                | 23e. Did t                                  | obacco use         | contribute to                          | the cause of death?                  |
| Division of Vital Records, | w require<br>been sig<br>should b   | ed             |  |  |                             |                                   |                        |                             | _ 10'                                       | Yes 2□N            | lo 3 🗆 Pro                             | bably 4 Unknown                      |
| ဓင္                        | e law requ<br>has been<br>je 2 shoul  | Completed      |  |  |                             |                                   |                        |                             | 24a. Was                                    |                    | 4b. Were aut                           | opsy findings available              |
| <u>~</u>                   |   | Соп            |  |  |                             |                                   |                        |                             |   | rmed?              | prior to co<br>death?<br>1 🗌 Yes       | omptetion of cause of                |
| Vit?                       | nysician: Th<br>nis certificate<br>director, pag  | Be             | 25. Was case referred to medical examiner?   | Hoopitali  |                             |                                   |                        |                             | Death (Check only o                         |                    |  |                                      |
| ō                          | ± ± m   | 1. To          | 1 ☐ Yes 2 ☐ No<br>27. Manner of Death  | Hospital: 1 Inpatie  |                             |                                   |                        | 4 🗀 14013111                | g Home 5 Resid                              |                    |  | <i>f</i> v)                          |
| <u>0</u>                   | nding l<br>ath.<br>r: After<br>e funer  | atlor          | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investiga  |  | Year) In                    | jury                              | 28c. Injury :<br>Work? | es 2 No                     | 28d. Describe I                             | now injury oc      | curred                                 |                                      |
| N N                        | Attendi<br>er death.<br>rector: A<br>by the fu  | Certification; | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin  | and 286. Place of Inju   | ury - At home, fare         | n, street, facto                  |                        |                             | 28f. Location (S                            | Street and No      | umber or Run                           | al Route Number.                     |
|                            | ital or<br>urs afte<br>ral Dire   | Cer            |  | building, etc  |                             |                                   |                        |                             | City or Tov                                 | vn, State)         |  |                                      |
|                            | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the  | Medical        | 29a. Certifier 1 Certifying (Check only one) 2 Medical E   | Physician: To the best of xaminer: On the basis of and manner sta  | examination and             | death occurre<br>or investigation | d at the time          | , date and planion, death o | ace, and due to the                         | cause(s) and       | manner as s                            | itated.                              |
|                            | vithin<br>Fo the  | Me             | 29b. Signature and title of certifier  | and manner sta   | 1100.                       | 2:                                | c. License             | number                      | <u> </u>                                    | 29rl Date sin      | aned (Month                            | Day Year                             |
|                            |   |                | A/2 /  | 1511   |                             |                                   | 443                    | 3711                        |   | )<br>)             | ji ied (Worki),                        | 38 500                               |
| •                          | $\sigma_{l}$  | -              | 30. Name and address of person w   | no completed cause of de   | eath (ttem 23a) (T          | ype, Print)                       | , , ,                  | 114                         | (   | LUMPZ              | ger.                                   | C/3 2005                             |
|                            |   |                | A/1/2 /-15,0   | h post   | Swell.                      | Frosp                             | 1751                   | RAN                         | doillow                                     | a Mo               | verla.                                 | Dey, Year)  2 9, 2005                |
|                            | Sta<br>Registra   |                | 31. Date filed (Month, Day, Year)  DEC 2 9 20  | 32. Registra   | r's Signature               | colis                             |                        |                             |   |                    | 1                                      | 7                                    |
| 18                         | - 1 als   | 15             |  | The State of the s | - 17                        |                                   |                        |                             |   |                    |  |                                      |

CPM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f, pen# (851,125/06 TT State of Maryland / Department of Health and Mental Hygiene) 0 5 05-08751 Deborah Curtis For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 Deborah Curtis December 16:22 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Middle River 101 Ballard Avenue-2nd floor 8. Date of Birth (Month, Day, Year) May 30, 1952 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 Yrs. Marylánd 212-60-4774 53 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show the Medical Examiner must be notified at 1 ☐ Yes 2√5No Maryland Baltimore Middle River Director 28e-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ö 21220 U.S.A. 101 Middle River Road items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. tiled within 72 hours after 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes ŽŒNo Specify: Specify: þ White 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator Bar 10 other permit. Pages 1 and 2 should be tiled Deperment of Health and Mental Hygi Important: If Item 27 is marked other eny injury or other treumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Nobles Leonard Smith ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry Gordon Curtis, Jr. (Husband) 101 Middle River Road, Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dec. 29, 2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mixed Drug Intoxication (cocaine, methadone, fentanyl, cyclobenzaprine, oxycodone) Physician /Medical Due to (or as a consequence of) Examiner squentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in light assets Due to (or as a consequence of): Examiner rsicien end e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month jo 4□Pregnant at time of death 5 Other (specify) P.O. | ed by the detached i 9 Unknown be det Part II, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 4 Sunknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 Yes 2 No certificate 2□No 1 Xes Division of Vital Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 2

28a. Date of Injury India (Month, Day Year)

28b. Time of Injury M niner? examiner? 1X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE ို 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurre unk Certification: 1 Natural 5 Pending 1 ☐ Yes 2 🛣 No investigation death. 2 Accident the the 6X Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 101 Ballard Ave. 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Direct þ 4 Homicide etter found at home 2nd FL. Middle River, MD within 24 hours e To the Funerel I completely filled filled bellif Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 26, 2005 O.C.M.E. Jaska 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasha Z Greenbern M.D 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 2 9 2005 Registrar

|                       |  |                     | 1 - For Amend Item State of Maryland Control of Registrar Ce  | Prince of Death  | ental Hyg                                 | iene 05                            | 42046  |  |  |  |  |  |
|-----------------------|--|---------------------|---|--|---|------------------------------------|--|--|--|--|--|--|
|                       |  |                     | Decedent's Name (First, Middle, Last)   |  | 2. Date of Dea                            | th                                 | 3. Time of Death                                     |  |  |  |  |  |
|                       | Physicia   |                     | Oscar Charles Casto   |  | Dec 24                                    | Day Year<br>4, 2005                | 12:35 A  |  |  |  |  |  |
|                       | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death   |   | 4c. County of Dea                  |  |  |  |  |  |  |
|                       | LAGITIT  | ٠.                  | Erickson Renaissance Gardens  | Silver Spring  |   | Prince (                           | George's   |  |  |  |  |  |
| ľ                     | Funeral<br>Director  |                     | $\begin{array}{c ccccccccccccccccccccccccccccccccccc$   | If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.              | 8. Date of Birth<br>(Month, Day<br>Dec 7, | 9. Bi<br>1914 Oh                   | rthplace (State or Foreign<br>ountry)<br>10          |  |  |  |  |  |
|                       | pu 🕨   |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or t  | ocation  |   |                                    | 10d. Inside City Limits                              |  |  |  |  |  |
|                       | aryla<br>shov  | _                   | 0.1   |  |   |                                    | 1 ☐ Yes 2 🕏 No                                       |  |  |  |  |  |
|                       | 28e-1  | ect                 | Maryland Montgomery Sil   | ver Spring   |   | Og. Citizen of What C              | 21   |  |  |  |  |  |
|                       | with t   | Ö                   | 3142 Gracefield Road #619   | 20904  | '   | United                             |  |  |  |  |  |  |
|                       | sath is 23   | erai                |   |  | cify Yes or No-                           | 14. Race - Am                      |  |  |  |  |  |  |
| 396                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28e-1 show any figury or other traumette event, I're Madical Examitration and once. | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Wes 2 No Korean  Year or Dates:   | Was Decedent of Hispanic Origin? (Speilf Yes, specify Cuban, Mexican, Puerto F | lican, etc.)                              | Black, Wh                          | ite, etc.  |  |  |  |  |  |
| Ö                     | 2 hou  | Completed by        | 15. Decedent's Education 16a. Dec   | edent's Usual Occupation   | ıa.                                       | 16b. Kind of Busines               | s/Industry   |  |  |  |  |  |
| 215                   | thin 7   | pie                 | (Specify only highest grade completed)  (Giv  Elementary/Secondary (0·12)  College (1-4or 5+)   | e kind of work done during most of working DO NOT use retired)                 | 9   |                                    |  |  |  |  |  |  |
| 21                    | ad wil   | Con                 |   | ter  |   | Ceramics                           |  |  |  |  |  |  |
| pu                    | be file  | Be (                | 17. Father's Name (First, Middle, Last)   | 18. Mother's Name  |   |                                    |  |  |  |  |  |  |
| <u>yla</u>            | should bent marked   | ၉                   | Golia David Casto   | Mary Ali   |   |                                    |  |  |  |  |  |  |
| , Maryland 21215-0036 | 1 and 2 should be filed within Health and Mental Hygiene. Iem 27 is marked other than other traumetic event, If e M  |                     | Stella LaRue Casto (wife) 314   | ing Address (Street and Number or Rural<br>2 Gracefield Road ‡                 | 619, S:                                   | ilver Spri                         | ngs, MD20904   |  |  |  |  |  |
| ore                   | of He  |                     | 20a. Method of Disposition 20b. Place of Disposition 1 ♥ Burial 2 □ Cremation 3 □ Removal from State  | osition (Name of amatory or other place) $Jan 5,$                              |   | 20c. Location - City o             |  |  |  |  |  |  |
| Ë                     | Pag<br>ment<br>ant:<br>ury c   |                     | `4 Donation 5 □ Other (Specify) Maryland  | Veterans Cemetery  |   | Cheltenham                         |  |  |  |  |  |  |
| Baltimore,            | permit. Pages 1 Department of H Important: If Ite any injury or ot once.   |                     | V Cyntha A Jones MO1457   | Rd, Cli  | <del></del>                               | c 6633 01d<br>20735                |  |  |  |  |  |  |
| п                     |  |                     | 23a. Part1. Enter the disease, or complications that caused the death. Do not en<br>shock, or heart failure. List only one cause on each line.  | nter the mode of dying, such as cardiac or                                     | respiratory arr                           | est,                               | Approximate<br>Interval Between<br>Onset and Death   |  |  |  |  |  |
|                       | Physician  |                     | Immediate Cause (Final disease or condition Isihemil Car  | piomyopathy  |   |                                    | Cristi and Death                                     |  |  |  |  |  |
|                       | /Medical<br>Examiner   |                     | resulting in death)  Due to (or as a consequence of):   |  |   |                                    |  |  |  |  |  |  |
| п                     | ⊏xammer  |                     | Sequentially list conditions.  Atherosclerotil Cardiovascular Disease  Disease  |  |   |                                    |  |  |  |  |  |  |
|                       | ned  | ine                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events could be a consequence of the country of |  |   |                                    |  |  |  |  |  |  |
|                       | ecute<br>and<br>-trans   | Examiner            | that initiated events c.  resulting in death) Last  Due to (or as a consequence of):  |  |   |                                    |  |  |  |  |  |  |
| 760,                  | cian surial  | al E                | Due to (or as a consequence of).  |  |   |                                    |  |  |  |  |  |  |
| 687                   | cate b   | 2                   | d   |  | _   |                                    |  |  |  |  |  |  |
| Box                   | That the death certificate be executed to by the attending physician and detached for use as the burial-transit  | Physician/Med       |   | □Ectopic pregnancy □ Other (specify)   |   | 23d. Date of de<br>Month           | elivery<br>Day Year                                  |  |  |  |  |  |
| P.0                   | hat the  | P                   | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part I.  | 23e. Did to                               | bacco use contribute               | to the cause of death?                               |  |  |  |  |  |
| Records,              | o ped  | ed by               | Gangrene right foot, Atrial Fibrill   |  | 1 🗆 Y                                     | es 2□No 3□F                        | Probably 4 Whichown                                  |  |  |  |  |  |
| 000                   | aw requir<br>s been si<br>2 should   | Completed           |   |  | 24a. Was a                                | an 24b. Were a                     | autopsy findings available<br>completion of cause of |  |  |  |  |  |
| Re                    | The lay  | lwo                 |   |  | autop:<br>perfor<br>1  Yes                | med? death?                        | _  |  |  |  |  |  |
| Vital                 |  | 0                   | 25. Was case referred to medical  | 26. Place of Death   |   |                                    |  |  |  |  |  |  |
|                       | 99   | ToB                 | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient  | ent 3 DOA Other: 4\times Nursing Hon   | ne 5 Resid                                | ence 6 □Other (Sp                  | ecify)   |  |  |  |  |  |
| 0                     | nding Phy<br>th.<br>: After this<br>s funeral c  | n: T                | 27. Manner of Death 28a. Date of Injury 28b. Time   |  | 8d. Describe h                            | ow injury occurred                 |  |  |  |  |  |  |
| io                    | Attending<br>ir death.<br>ector: After<br>by the fune  | atio                | 1 XNatural 5 Pending (Month, Day Year) injury 2 Accident investigation  | M 1 ☐ Yes 2 ☐ No   |   |                                    |  |  |  |  |  |  |
| Division of           | D ir   | Certification:      | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)  | treet, factory, office   | 8f. Location (S<br>City or Tow            | treet and Number or F<br>n, State) | Rural Route Number,                                  |  |  |  |  |  |
|                       | The Funeral Completed of the Funeral Completely filled   |                     | 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, dea   | ath occurred at the time, date and place, a                                    | nd due to the c                           | ause(s) and manner a               | as stated.   |  |  |  |  |  |
|                       | he Ho<br>n 24<br>he Fu<br>pletel   | edical              | (Check only 2 Medical Examiner: On the basis of examination and/or and manner stated.   | _  |   |                                    |  |  |  |  |  |  |
|                       | 0 1  | Σ                   | 29b. Signature and title of certifier   | 29c. License number  | 2   | 29d. Date signed (Mor              |  |  |  |  |  |  |
| /                     | 241)   | 3                   | 1 January   | D24035   |   | Dec 27,                            | 2005   |  |  |  |  |  |
| (:                    | ライソ  |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type  |  |   |                                    |  |  |  |  |  |  |
| 1                     |  |                     | Eugenio MAchado, M.D. 3110 Gracefiel  |  | ing, MD                                   | 20904                              |  |  |  |  |  |  |
|                       | Sta<br>Regist  |                     | 31. Date filed (Month, Pay, Year) DEC 2 9 2005  | le le  |   |                                    |  |  |  |  |  |  |
|                       |  |                     |   |  |   |                                    |  |  |  |  |  |  |

|      |  |                | T = For State Registrar   | State of M   | larylan                       | •                                | artmen<br><i>tificat</i> e |                             |                            | ind Me      |  | jiene<br>leg. No.       | 05                         | 42                           | 047  |
|------|--|----------------|---|--|-------------------------------|----------------------------------|----------------------------|-----------------------------|----------------------------|-------------|--|-------------------------|----------------------------|------------------------------|--|
|      | Physicia   | an             | 1. Decedent's Name (First, Middle, Last)  |  |                               |                                  |                            |                             |                            |             | 2. Date of Dea<br>Month<br>Decembe         |                         | 5, 2 <sup>Yea</sup>        |                              | 3. Time of Death 4:00 a M                          |
|      | /Medic   | al             | Catherine M. Creta  4a. Facility Name (If not institution, give st  |  | )                             |                                  | 4b. City,                  | Town, or                    | Location of                |             | Decembe                                    |                         | County of De               |                              | 4:00 a **  |
|      | Examin   | er             | 3708 Grier Nursery  |  |                               |                                  |                            | eet                         |                            |             |  |                         | Harfo                      | rd                           |  |
|      | Funeral<br>Director  |                | 5. Social Security Number 6. Sex  |  |                               | last birthday)<br>Yrs.           | If Under<br>Months         | 1 Year<br>Days              | If Under 2<br>Hours        | Min.        | 8. Date of Birth<br>(Month, Day<br>Feb. 28 | 8, 19                   | 9. E                       | Birthplac<br>Country<br>I eW | Jersey   |
|      | and w  |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City                     | y, Town or Lo                    | cation                     |                             |                            |             |  |                         |                            | 10d.                         | . fnside City Limits                               |
|      | Maryl  | tor            | Md. Harford   | l  |                               |                                  |                            | Str                         | eet                        |             |  |                         |                            |                              | 1 ☐ Yes 2 🖺 No                                     |
|      | or 286   | Director       | 10e. Street and Number<br>3708 Grier Nursery  | Pond   |                               |                                  | 10f. Zip                   |                             | 21154                      |             | 1  |                         | en of What                 | Country                      | 17   |
|      | sath w   | erall          |   | 2. Was Deceden   | Fver in U                     | S 13 V                           | Vas Decer                  |                             |                            | in? (Spec   | cify Yes or No-                            |                         | S.A.<br>4. Race - Ar       | merican                      | Indian,  |
| 200  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department if them 27 is marked other then "netural", or items 23a or 28e-f show any injury or other treumatic event, the Madical Examinal must be mailtied at once.                       | by Funeral I   | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | Armed Forces  1 Yes 2   If Yes, Give  Year or Dates:           | ?<br>No                       | f                                | f Yes, spec                | ify Cuban                   | Specify:                   | , Puerto R  | lican, etc.)                               |                         | Black, Wi<br>Specify: V    | hite, etc                    |  |
|      | 72 hou<br>netura<br>lical E  |                | X<br>15. Decedent's Educi<br>(Specify only highest grade  | ition<br>completed)  |                               | 16a. Deced                       | kind of wo                 | rk done di                  | uning most                 | of workin   | g  | 16b. Kin                | d of Busines               | ss/Indus                     | stry   |
| 4    | withlin no.  | Completed      | Elementary/Secondary (0-12)   | College (1-4or   | 5+)                           | life. L                          | DO NOT us                  | se retired)                 |                            |             |  |                         | own ho                     | nme                          |  |
| 3    | filed v<br>Hygie<br>other t  | e Co           | 12 years<br>17. Father's Name (First, Middle, Last)   |  |                               | nome                             | make                       |                             | 18. Mother                 | r's Name    | (First, Middle,                            |                         |                            | Jiic                         |  |
| a    | uld be<br>Aental<br>rked c   | To B           | Nicholas Matteucc   | i.   |                               |                                  |                            |                             | Anı                        | ne Al       | Ld1  |                         |                            |                              |  |
| Mai  | d 2 sho<br>th and h<br>th sma<br>?7 is ma<br>treuma  | •              | 19a. Informant's Name/Relationship (Type<br>Ralph Cretaro/son   | e, Print)  |                               |                                  |                            |                             |                            |             | Route Number                               |                         |                            |                              |  |
| נֿי  | s 1 an<br>of Heal<br>item 2<br>other   |                | 20a. Method of Disposition  |  |                               | Place of Dispo                   | sition (Nam                | ne of<br>ther place         | 9)                         | Da          | ate  | 20c. Loc                | ation - City               | or Town                      | , State  |
| 2    | Page<br>nent c<br>ent; if<br>ury or  |                | 1 ☐ Burial 2 ☐ Cremation 3 🚰 Re `4 ☐ Donation 5 ☐ Other (Specify)   | moval from State   |                               | . John                           |                            |                             |                            | 12/30       | 0/05                                       | Cha1                    | font,                      | Pa.                          |  |
| Day  | permit. Departr importr any inj  |                | 21. Signature of Funeral Service Logises  | i  |                               | 6                                | 10 W                       | Mac                         | Phai                       | 1 Roa       | Home of ad, Bel                            | Air                     |                            |                              |  |
| ī    |  |                | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one                            | ations that cause<br>cause on each                             |                               | h. Do not ent                    | er the mod                 | e of dying                  | , such as                  | cardiac or  | respiratory arr                            | est,                    |                            | A In                         | pproximate<br>Iterval Between<br>Inset and Death   |
| F    | Physician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)   |  |                               |                                  | VB                         | sal                         | on                         | ()(         | sessi                                      |                         |                            | 0                            | Jen.   |
| 1    | Examiner   |                |   | Due to (or a   | s a conseq                    | uence of):                       |                            |                             |                            |             |  |                         |                            |                              |  |
| Ц    | n =  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or a   | s a conseq                    | uence of):                       |                            |                             |                            |             |  |                         |                            |                              |  |
|      | be executed<br>sician and<br>burial-transit  | Examiner       | Cause (Disease or injury that initiated events c. resulting in death) Last                                  | Due to (or a   | s a consed                    | uence of):                       |                            |                             |                            |             |  | -                       |                            |                              |  |
| 5    | ate be ex<br>hysician<br>the burial  | dical E        |   | 540 10 (0. 4.  |                               |                                  |                            |                             |                            |             |  |                         |                            |                              |  |
|      | tificate<br>ig phys<br>as the  | ledic          | u.  |  |                               |                                  |                            |                             |                            |             |  |                         |                            |                              |  |
| , DO | To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death. within 24 hours after death. To the Funerie Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as to | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                     | c. If yes, outcom<br>1 Live birth<br>4 Pregnant a<br>9 Unknown | 2 Feta                        | Ideath 3□                        | Ectopic pr<br>Other (sp    |                             |                            |             |  | 23                      | 3d. Date of d<br>Month     | lelivery<br>Da               | ay Year  |
|      | w requires that the de<br>been signed by the<br>should be detached   |                | Part II. Other significant conditions cont  | nbuting to death   | but not res                   | ulting in the ur                 | nderlying c                | ause give                   | n in Part f.               |             | 23e. Did to                                | bacco us                | e contribute               | to the                       | cause of death?                                    |
| 2    | quires<br>n sign<br>uld be   | ed by          |   |  |                               |                                  |                            |                             |                            |             | 1 🗆 Y                                      | es 2 🗆                  | No 3□                      | Probab                       | ly 4 Unknown                                       |
| 2201 | he law rei<br>e has bee<br>age 2 sho   | Completed      |   |  |                               |                                  |                            |                             |                            |             | 24a. Was a autops perform                  | sy                      | 24b. Were prior to death'  | o comp                       | / findings available<br>letion of cause of<br>☐ No |
|      | ien:<br>rtifical<br>ctor, p  | Be C           | 25. Was case referred to medical examiner?  |  |                               |                                  |                            |                             | 26. Place                  | of Death    | (Check only or                             | 7                       |                            |                              | ASSISFER   |
|      | Physic<br>this ce<br>al dire   | To             | 1 ☐ Yes 2 ☐ No  | spital:<br>1  Inpat<br>28a. Date of Inj                        |                               | ER/Outpatien                     |                            |                             | 4 [] Nul                   |             | e 5 ☐ Reside                               |                         | Occurred                   | pecify)                      | Care   |
| 5    | ding h   | tlon           | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | (Month, D  | ay Year)                      | Injury                           | M                          | 8c. Injury<br>Work<br>1 🗌 Y | ai<br>?<br>′es 2 □ N       |             | od. Describe in                            | OW III JULY             | occurred                   |                              | PACICITY   |
| 1000 | To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certilicate has completely filled in by the funeral director, page 2   | Certification: | 3 Suicide 6 Could not be determined   | 28e. Place of Ir<br>building, e                                | njury - At ho<br>atc. (Specif | ome, farm, str<br>y)             | eet, factory               | , office                    |                            | 28          | Bf. Location (Si<br>City or Town           |                         | Number or                  | Rural R                      | loute Number,                                      |
|      | Hospite<br>24 hours<br>Funerei<br>etely filled   | edical C       | 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examina                                       | cien: To the bes<br>er: On the basis<br>and manner s           | of examina                    | wledge, death<br>tion and/or inv | occurred<br>restigation    | at the time<br>, in my op   | e, date and<br>inion, deat | d place, ar | nd due to the c<br>d at the time, d        | ause(s) a<br>late and p | ind manner<br>place, and d | as state<br>ue to th         | ed.<br>e cause(s)                                  |
|      | To th<br>within<br>To the  | Me             | 29b. Signature and title of certifier   |  | _                             |                                  | 290                        | . License                   | number                     | G.C         | 2  | 29d. Date               | signed (Mo                 | n <i>th</i> , Da             | y, Year)   |
| -    | <  |                | · anly  | - MI   | ?                             |                                  |                            | DJ                          | 888                        | 77          |  | De                      | < 28                       | 1, 7                         | 200)   |
| 0    | \  |                |   | SPAN   | U                             | C 15                             | Print)                     | Mp                          | cph                        | Loil        | Bel  | oin                     | MO                         | , ,                          | 200)   |
|      | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) DEC 2 9   | 32. Regi   | rar's Signa                   | iture                            | book                       | وع                          |                            |             |  |                         |                            |                              |  |

| .K.                        | S  | S (                    | Please   | Type or Pri   |                              |                                 |   |                            |                | -                                     |                                    | gible.                    |  |
|----------------------------|--|------------------------|--|---|------------------------------|---------------------------------|---|----------------------------|----------------|---------------------------------------|------------------------------------|---------------------------|--|
| 2,120                      |  |                        | For<br>State<br>Registrar  | State of M  | aryland                      |                                 | artment of t<br>rtificate of                                |                            |                | entai Hy                              | rgiene<br>Reg. No.                 | 05                        | 42048  |
|                            |  |                        | Decedent's Name (First, Middle, L.   | a st)   |                              |                                 |   |                            |                | 2. Date of De                         |                                    | Year                      | 3. Time of Death                                   |
|                            | Physici<br>/Medi   | al                     | BENTON WILLIS  | CHAMBER   | S S                          | SR.                             |   |                            |                | DEC.                                  | 24, 2                              | .005                      | 20:15P M   |
|                            | Examir   | ier                    | 4a. Fecility Name (If not institution, g<br>2536 WASHINGTON                                      |   |                              |                                 | 4b. City, Town, o   |                            |                |                                       | 4c. Cou                            | nty of Dea                | th   |
|                            | Funeral<br>Director  |                        | 5. Social Security Number 6. 214–38–2263   | 10011 2000  | 90 (In yrs. la<br>54         | ast birthday)<br>Yrs.           | If Under 1 Year<br>Months Days                              |                            | Min.           | B. Date of Bi<br>(Month, D<br>Jan . 1 | th Year) 8, 194                    |                           | thplace (State or Foreign<br>puntry)<br>laryland   |
|                            | and  |                        | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City                    | , Town or Lo                    | ocation   |                            |                |                                       |                                    |                           | 10d. Inside City Limits                            |
|                            | Maryl a-f eho  | to                     | Maryland N/A   |   | Ва                           | altimo                          | re  |                            |                |                                       |                                    |                           | 1 ✓ Yes 2 □ No                                     |
|                            | death with the Maryland<br>ome 23a or 28a-f ehow<br>if must be collified at  | Funeral Director       | 10e. Street and Number<br>2536 Washington  | Blvd.   |                              |                                 | 10f. Zip Code 212   | 30                         |                |                                       | 10g. Citizen                       | of What C                 | •  |
| Maryland 21215-0036        | or its   |                        | 11. Marital Status  1 □ Never Married 2 □ Married  3 Ø Widowed 4 □ Divorced                      | 12. Was Decedent Amed Forces? 1  Yes 2 If Yes, Give Year or Dates:      | ,                            | 1                               | Was Decedent of I<br>If Yes, specify Cub                    |                            |                | ify Yes or Nican, etc.)               |                                    | Black, Whi                | erican Indian,<br>te, etc.<br>iite                 |
| 15-0                       | 72 hours<br>"naturel",   | eted                   | 15. Decedent's<br>(Specify only highest g  | Education rade completed)   |                              | 16a. Deced                      | dent's Usual Occu<br>kind of work done<br>DO NOT use retire | pation<br>during mo        | st of workin   | 9                                     | 16b. Kind o                        | of Business               | /Industry  |
| 121                        | be tiled within 72 hotal Hygiene. Id other then *natu  | Completed by           | Elementary/Secondary (0-12)  | College (1-4or  | 5+)                          | _                               | penter  | эа)                        |                |                                       | Se1                                | f-Emp                     | loyed  |
| Dd.                        | al Hyg<br>I other  | BeC                    | 17. Father's Name (First, Middle, La.  | st)   |                              |                                 |   | 18. Moti                   | her's Name     | (First, Middle                        | , Maiden Sur                       | name)                     |  |
| ya                         | 12 should be filed within h and Mental Hygiene. 7 is marked other then *   | 5                      | Monty Chamber  |   |                              |                                 |   |                            | rence          |                                       | nkown                              |                           |  |
| Mai                        | th and 2 sh and 2 sh and 27 ls m   |                        | 19a. Informant's Name/Relationship  Jessica Chambers   | 7.71  | nter)                        |                                 | ng Address <i>(Str</i> eet<br>Deering                       |                            |                |                                       | -                                  |                           |  |
| Je,                        | of Hear<br>item  |                        | 20a. Method of Disposition  1  Burial 2 Cremation 3  |   | 20b. Pl                      | ace of Dispo                    | sition (Name of<br>natory or other pla                      | ice)                       | Da             | te                                    |                                    |                           | Town, State  |
| Baltimore,                 | ment tant: If tant: If jury or   |                        | 4 Donation 5 Other (Spec   | eify)   |                              | yview                           | Cremator  | У                          | 12-30          | 1,34                                  |                                    |                           | Maryland   |
| Bal                        | permit. Peges 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumatic ence. |                        | 21. Signature of Funeral Service Lic   | Pann  | M                            | 13                              | Name and Addre<br>CU11y-P<br>CEast F                        | olyni<br>ort A             | ak Fu<br>venue | neral<br>, Balt                       | Home P<br>imore,                   | ·A.<br>Mary               | land 21230   |
|                            |  |                        | 23a art1. Enter the disease, or co<br>shock, or heart failure. List on<br>immediate Cause (Final | mplications that cause<br>y one cause on each li                        |                              |                                 |   |                            |                |                                       |                                    |                           | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician<br>/Medical  |                        | disease or condition resulting in death)   | a. Due to (or as  | a consequ                    | ence of):                       | c Caval   | IOVAS                      | cireu          | 1 12                                  | rsea                               | se                        |  |
|                            | Examiner   |                        | Sequentially list conditions,  | b   |                              |                                 |   |                            |                |                                       |                                    |                           |  |
|                            | hed nsit   | Examiner               | fany, leading to immediate cause. Enter Underlying Cause (Disease or injury                      | Due to (or as   | a consequ                    | ence of):                       |   |                            |                |                                       |                                    |                           |  |
| ,<br>0,                    | executed<br>en and<br>rial-transi  | Exan                   | that initiated events<br>resulting in death) Last  | C. Due to (or as  | a consequ                    | ence of):                       |   |                            |                |                                       |                                    |                           |  |
| 6876                       | icate be<br>physicie<br>s the bur  | icai                   |  | d   |                              |                                 |   |                            |                |                                       |                                    |                           |  |
| Box                        | ne death certil<br>the attending<br>thed for use a   | Physician/Medical      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 IQ No 9 □ Unknown         | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 Fetal                      | death 3                         | Ectopic pregnanc<br>Other (specify)                         | ÿ                          |                |                                       | 23d.                               | Date of de<br>Month       | livery<br>Day Year                                 |
| , P.O.                     | thet the   | y Ph                   | Part II. Other significant conditions  | contributing to death b   | ut not resu                  | Iting in the ur                 | nderlying cause gr  | ven in Part                | 1.             | 23e. Did                              | tobacco use o                      | contribute to             | o the cause of death?                              |
| rds                        | w requires<br>been sign<br>should be   | ed b                   | Congestive   | Heart D   | 1810                         | 50                              |   |                            |                | 1 🗆                                   | Yes 2□N                            | o 3□P                     | robably 4 Unknown                                  |
| Division of Vital Records, |  | Completed by           | Atrial h   | nrillateu   | n                            |                                 |   |                            |                | 24a. Was<br>auto<br>perfe<br>1 Yes    | s an 24<br>psy<br>ormed?<br>2 X No | death?                    | utopsy lindings available completion of cause of   |
| Vita                       | Attending Physicien: Thirdeath. creath. ector: After this certificate by the funeral director, pag                                 | Be                     | 25. Was case referred to medical examiner?   | Hospital:   |                              |                                 | 04  |                            |                | Check only                            | one)                               |                           |  |
| ō                          | Phys<br>r this<br>and dir  | : To                   | 1  Yes 2 No<br>27. Manner of Death   | 28a. Date of Inju<br>(Month, Da   |                              | FVOutpation<br>28b. Time of     | 3 DOA   |                            |                |                                       | idence 6 🔀                         |                           | city)AT SCENE                                      |
| ion                        | ath.<br>rr: After  | atior                  | 1 Natural 5 ☐ Pending investigation  |   | y Year)                      | Injury                          |   | ork?<br>]Yes 2[            | ]No            |                                       |                                    |                           |  |
| Divis                      | 5 # 5 S  | Medical Certification: | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine  | be<br>d 28e. Place of In<br>building, et                                | ury - Al hor<br>c. (Specify) | me, farm, sir                   | eet, lactory, office  |                            | 28             | 8f. Location (<br>City or To          | (Street and Nu<br>wn, State)       | umber or R                | ural Route Number,                                 |
|                            | ne Hospital<br>24 hours a<br>ne Funerel C  | edicai                 | 29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex                                      | Physician: To the best<br>aminer: On the basis o<br>and manner st       | f examinati                  | vledge, death<br>ion and/or inv | n occurred at the ti<br>vestigation, in my                  | ime, date a<br>opinion, de | and place, ar  | d due to the<br>d at the time,        | cause(s) and<br>date and pla       | l manner a<br>ce, and due | s stated.  to the cause(s)                         |
|                            | Withii To th   | M                      | 29b. Signature and title of certifier  | 10.0  | (                            | )                               | 29c. Licen:   |                            |                |                                       |                                    |                           | th, Day, Year)                                     |
| •                          | 0  |                        | · Carol  | Halla   | uus                          | <u> </u>                        |   | .C.M.                      |                |                                       | DEC.                               | 27,                       | 2000   |
|                            | ( '  |                        | 30. Name and address of person wh  | completed cause of c  | leath (Item                  | 23a) (Type<br>11 PEN            | N STREET  | , BAL                      | TIMOR          | E,MARY                                | LAND 2                             | 1201                      |  |
|                            | Sta  |                        | 31. Date filed (Month, Day, Year)  |   | ar's Signati                 |                                 | 6 4   |                            |                |                                       |                                    |                           |  |
|                            | Regist   |                        | DEÇ 2 9  | 2005  | ار مریخ                      | C. A                            | one   |                            | 2017 = -       |                                       |                                    |                           |  |
| DH                         | MH 17 Rev 1/2  | J01                    |  |   |                              | \$ ODIC:                        |   |                            |                |                                       |                                    |                           |  |

|                     |   |                | 1 - State of Mary  |  | artment of H                                |                                |                                  | ene 05                                  | 42049   |
|---------------------|---|----------------|--|--|---|--------------------------------|----------------------------------|---|---|
| ,                   |   |                | Decedent's Name (First, Middle, Last)  | -                                      |   |                                | 2. Date of Death                 |   | 3. Time of Death                                  |
| ш                   | Physici   |                | MARY LEONISSA (  | CLEMENTS                               |   |                                | December                         | 23, 200°                                | 5 9:43 A. M                                       |
|                     | /Medio  |                | 4a. Facility Name (If not institution, give street and number)   |  | 4b. City, Town, or                          | Location of Death              |                                  | 4c. County of De                        | 1-1-1-  |
|                     |   |                | St. Joseph Medical Center  |  | Towson                                      | 1                              |                                  | Baltimo                                 | re  |
|                     | Funeral   |                | 5. Social Security Number 6. Sex 7. Age (In  | n yrs. last birthday)                  | If Under 1 Year<br>Months Days              | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, | 9 F                                     | irthplace (State or Foreign                       |
|                     | Director  |                | 182-48-1040 1□M 2XF 91   | Yrs.                                   | Wichillis Days                              | Hodis Will.                    | Dec. 2,                          | 1914 Wa                                 | Shington D.C.                                     |
|                     | pu *  |                | Usual Residence of Decedent           10a. State         10b. County         10                            | Oc. City, Town or Lo                   | antina                                      |                                |                                  |   | 104 1-14-05-11-5-                                 |
|                     | eho   | 5              |  |  |   |                                |                                  |   | 10d. Inside City Limits 1 Tyes 2 No               |
|                     | the N   | Director       | Maryland Baltimore   | Baltin                                 | 10f. Zip Code                               |                                | 100                              | g. Citizen of What                      |   |
|                     | With of a   |                | 6401 N. Charles Street   |  |   | 1010                           | 100                              |   | Country?  |
|                     | eath  | era            | 11. Marital Status 12. Was Decedent Ever   | rin U.S. 13. V                         |   | 21212<br>spanic Origin? (Sp    | acify Yes or No-                 | U.S.A.                                  | nerican Indian,                                   |
|                     | r Iten  | Funeral        | Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No  |  | Was Decedent of His<br>f Yes, specify Cubar | n, Mexican, Puerto             | Rican, etc.)                     | Black, Wi                               |   |
| 3                   | hours after death with the Maryland<br>turel', or Iteme 23e or 28e-f ehow<br>at Examinar must be motified at  | by             | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:   | 1                                      | !□Yes 2X No                                 | Specify:                       |                                  | Specify:                                | White   |
| 0                   | 72 ho   | Completed      | 15. Decedent's Education<br>(Specify only highest grade completed)   |  | ient's Usual Occupa<br>kind of work done d  |                                | 16                               | 6b. Kind of Busines                     | ss/industry                                       |
| 21                  | filed within 72<br>Hygiene.<br>ether then "nate<br>ent, the Medic   | npie           | Elementary/Secondary (0-12) College (1-4or 5+)   | life. L                                | DO NOT use retired)                         | )                              | ing                              |   |   |
| 2                   | filed withi<br>Hygiene.<br>other them   | Co             | 4 years  | Te                                     | eacher                                      |                                |                                  | Education                               | on  |
| D                   | tal H<br>d ott  | Be             | 17. Father's Name (First, Middle, Last)  |  |   | 18. Mother's Name              | e (First, Middle, Ma             | aiden Sumame)                           |   |
| <u>X</u>            | should be<br>ind Mental.  | ဥ              | Eugene Clements  |  |   | Mary                           | Riege                            | er                                      |   |
| Maryland 21215-0036 | 2 short and reum  |                | 19a. Informant's Name/Relationship (Type, Print)   |  | g Address (Street a                         |                                |                                  |   |   |
|                     | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene if Health and Mental Hygiene team 23e or 28e-f ehow then 17 is marked other then "neturel", or Iteme 23e or 28e-f ehow other treumatic event, the Medical Exertifier must be notified at |                | Sr. Bernice Feilinger, SSND  | 6401                                   | N. Charle                                   | s St. Ba                       |                                  |   |   |
| פֿר                 | Pages<br>nent of h<br>int: if Its<br>iry or of  |                | EM Duliai 2   Cremation 3   nemovalifor State  | 20b. Place of Dispos<br>cemetery, crem |   |                                |                                  | c. Location - City                      |   |
| Baltimore,          | rt. Parturant   |                |  | Villa Mar                              |   |                                |                                  | len Arm,                                | Maryland  |
| Ba                  | permit. Pages<br>Department of I<br>Important: If Its<br>eny injury or or   |                | 21. Signature of Funeral Service Licensee  | M                                      | Name and Addres<br>litchell-V<br>6500 York  | viedefeld                      | Funeral                          | Home, Ir                                | ic.   |
|                     | <b>%</b> i  |                | 23a. Part1. Enter the disease, or complications that caused the  | death. Do not ent                      | 6500 York                                   | Road B                         | altimore                         | , Marylar                               | nd 21212<br>Approximate                           |
|                     |   |                | shock, or heart failure. List only one cause on each line.   | 71                                     | 0   | .1                             | or respiratory arres             | ι,                                      | Interval Between Onset and Death                  |
|                     | Physician<br>/Medical   |                | disease or condition resulting in death)   | 1 NOZCAR                               | v yeerd                                     | em 1                           |                                  |   | (1) Vax   |
|                     | Examiner  |                | Due to (or as a co   | insequence of):                        |   |                                |                                  |   | 0   |
|                     |   | e              | Sequentially list conditions, if any, leading to immediate Due to (or as a co                              | onsequence of):                        |   |                                |                                  |   |   |
|                     | uted<br>d<br>ansit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.     |  |   |                                |                                  |   |   |
| o î                 | exec<br>an an<br>rial-tr  | Exa            | resulting in death) Last  Due to (or as a co   | nsequence of):                         |   |                                |                                  |   |   |
| 8760                | The law requires that the death certificate be executed to hes been signed by the attending physicien and agge 2 should be detached for use as the burial-transit   | dicai          | d  |  |   |                                |                                  |   |   |
| 0                   | ng ph<br>as th  | Medi           | 15.555   |  |   |                                |                                  |   |   |
| ROX                 | eath certific<br>attending p  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of p. 1 ☐ Live birth 2 ☐ |  | Ectopic pregnancy                           |                                |                                  | 23d. Date of d                          |   |
|                     | a dea<br>he att   | SCI            | 1 Yes 2 No 4 Pregnant at time  |  | Other (specify)                             |                                |                                  | Month                                   | Day Year  |
| J.                  | at the de   | Phy            | э 🗆 Оикпоми  |  |   |                                |                                  |   |   |
|                     | ires tha<br>signed I  | þ              | Part If. Other significant conditions contributing to death but no   | of resulfing in the un                 | iderlying cause give                        | n in Part I.                   |                                  |   | to the cause of death?                            |
| 20                  | w requir<br>been si<br>should   | ted            |  |  |   |                                | 1 Tes                            | 2 Ø No 3 ☐ F                            | Probably 4 Unknown                                |
| Hecords,            | hes b   | Completed      |  |  |   | -                              | 24a. Was an autopsy              | / prior to                              | autopsy findings available completion of cause of |
|                     |   | Sol            |  |  |   |                                | performe<br>1 ☐ Yes 2            | death?<br>No 1 ☐ Ye                     | s 2 No  |
| Vital               | Physicien: The this certificete   | Be             | 25. Was case referred to medical examiner?   | -1                                     |   | 26. Place of Death             | (Check only one)                 |   |   |
| 6                   | Physic<br>this c  | မ              | 1 Yes 2 No Hospital: 1 Inpatient   | 2 ER/Outpatient                        |   | 4   Nursing no                 | me 5 Residence                   |   | ecify)  |
|                     | ding F<br>h.<br>After<br>funeri   | <u>o</u>       | 27. Manuar of Death  1 Natural 5 ☐ Pending  28a. Date of Injury (Month, Day Ye                             | par) 28b. Time of Injury               | 28c. Injury<br>Work                         |                                | 28d. Describe how                | injury occurred                         |   |
| S                   | or Attending<br>ifter death.<br>Director: After<br>in by the fune   | icat           | 2 Accident Investigation 3 Suicide 6 Could not be  | At home for the                        |   | es 2 No                        | 206 1 (04                        |   |   |
| DIVISION            | or A<br>after<br>Direct<br>in by  | Certification: | 4 Homicide determined 28e. Place of Injury building, etc. (S   | pecify)                                | eet, ractory, office                        |                                | City or Town, S                  |   | Rural Route Number,                               |
| _                   | Hospitel or<br>24 hours afte<br>Funeral Di<br>tely filled in  |                | 29a. Certifier Certifying Physicien: To the best of m  | v knowledge death                      | occurred at the time                        | a data and place of            | and due to the cour              |   |   |
|                     | Fur h   | Medical        | (Check only 2 Medical Examiner: On the basis of exa and manner stated.                                     | amination and/or inv                   | estigation, in my opi                       | inion, death occurr            | ed at the time, date             | se(s) and manner a<br>and place, and du | is stated.<br>ie to the cause(s)                  |
|                     | within 2<br>To the<br>complet   | Me             | 29b. Signature and title of certifier  | AHOND                                  | 29c. License                                | number                         | 29d                              | . Date signed (Mor                      | nth, Day, Year)                                   |
|                     | ->-0  |                | Med M. Fred and in me  | ) Winder                               | in Morxla                                   | 1 05481                        | 73                               | Dogambo                                 | 12 2005   |
|                     | 1   |                | 30. Name and address of person who completed cause of death  | (h- 00-) (T - F                        | 2   | 3                              | <i>a</i> ) -                     | December                                | . 1   |
|                     | \<br>   | •              | AZG WAJ OZISZ W ZAZN   | f, a. D. If                            | 20111C                                      | nonles St.                     | Suite 518                        | s batto, 1                              | 1/d 21204   |
| \$.<br>*/           | Sta<br>Registr  |                | DEC 2 9 2005   | Signature                              |   |                                |                                  |   |   |

|                            |  |                   | 1 - For<br>State<br>Registrar   | State of Maryland / Depa   | artment of Health and M<br>rtificate of Death                                 | lental Hygie                        | / 11 15                          | 42050   |  |  |  |  |
|----------------------------|--|-------------------|---|--|---|-------------------------------------|----------------------------------|---|--|--|--|--|
|                            |  |                   | Decedent's Name (First, Middle, Last)   |  |   | 2 Date of Death                     |                                  | 3. Time of Death                                |  |  |  |  |
| ı                          | Physici  |                   | Edward  | Colley   |   | December                            | 25, 2005                         | 10:23 p.™                                       |  |  |  |  |
| E.                         | /Medic<br>Examir   |                   | 4a. Facility Name (If not institution, give str   | eet and number)  | 4b. City, Town, or Location of Death  |                                     | 4c. County of Death              | 1 P   |  |  |  |  |
| 1                          |  |                   | Johns Hopkins Hosp  | ital   | Baltimore   |                                     | NIA                              |   |  |  |  |  |
| ī                          | Funeral  |                   | Social Security Number     6. Sex   | 7. Age (In yrs. last birthday)   | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                      | 8. Date of Birth<br>(Month, Day, Ye | 9. Birthp                        | place (State or Foreign                         |  |  |  |  |
| H                          | Director   | ı                 | 299-39-0697   | 4 2 F 70 Yrs.  | Working Day's Front's INNT.   | Nov. 11,                            | 1935                             | ""SC  |  |  |  |  |
|                            | pue *  | }                 | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or Lo  | cation  |                                     | 1                                | 10d. Inside City Limits                         |  |  |  |  |
|                            | /anyla   | 5                 | MD N/A  | Balte  |   |                                     |                                  | 1 Yes 2 □ No                                    |  |  |  |  |
|                            | 28a-   | Director          | 10e. Street and Number  | 02111  | 10f. Zip Code   | 10a                                 | Citizen of What Cour             |   |  |  |  |  |
|                            | with with  | ā                 | 2249 East F   | Proston SI   | 21213   | 1.09.                               | USA                              | My:   |  |  |  |  |
|                            | leath  | Funeral           |   | . Was Decedent Ever in U.S. 13.1   | Was Decedent of Hispanic Origin? (Sp<br>f Yes, specify Cuban, Mexican, Puerto | ecify Yes or No-                    | 14. Race - Americ                | can Indian,                                     |  |  |  |  |
| (0                         | ifter of the contract of the c | 臣                 | 1 Never Married 2 Married   | 1 ☐ Yes 2 📆 No   | ,   | Rican, etc.)                        | Black, White,                    |   |  |  |  |  |
| 93                         | ours after death with the Marylan<br>rat', or items 23a or 28a-f show<br>Exteriliner rount be notified at  | þ                 | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 25 No Specify:  |                                     | Specify: B                       | ack   |  |  |  |  |
| 21215-0036                 | n 72 hours after death with the Maryland<br>"natural", or itams 23a or 28a-f show<br>solical Expenies must be notified at  | Completed         | 15. Decedent's Educa<br>(Specify only highest grade of                                      |  | dent's Usual Occupation<br>kind of work done during most of work              |                                     | . Kind of Business/In            |   |  |  |  |  |
| 2                          | within<br>ene.<br>then   | ng u              | Elementary/Secondary (0-12)   | College (1-4or 5+)   | DO NOT use retired)   | 9                                   | Baltin                           | ore City  |  |  |  |  |
|                            | - '- h   | ပွဲ               |   | 5+   | Teacher   |                                     |                                  | Schools   |  |  |  |  |
| pu                         | be fill<br>ital H<br>id oth  | Be                | 17. Father's Name (First, Middle, Last)   | 1  | 18. Mother's Name   | First, Middle, Maid                 | den Sumame)                      |   |  |  |  |  |
| yla                        | Mer Mer  | မ                 | Harry Coli  |  |   | nell K                              | Miams                            |   |  |  |  |  |
| Maryland                   | 12 st<br>h and<br>7 ts n<br>traun  |                   | 19a. Informant's Name/Relationship (Type  | 10 11 1 00   | ng Address (Str. et and Number or Run   | 1                                   | 10 10                            |   |  |  |  |  |
| -                          | ges 1 and 2 should be filed<br>t of Health and Mental Hyg<br>If item 27 is marked othe<br>or other traumatic avent,  |                   | Jeroine William  20a. Method of Disposition   | 20b. Place of Dispo  |   |                                     | Ho MD .<br>Location - City or To |   |  |  |  |  |
| Baltimore                  | ages<br>It of l  |                   | 1 Surial 2 □ Cremation 3 □ Ren  | cometery, crer   | natory or other place)  |                                     | 1                                |   |  |  |  |  |
| ij                         | nit. Pa<br>entmen<br>ortant:<br>injury<br>a.   |                   | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee                 | 1 VW ite   | 1 Cemetery Dec-   | 1,200                               | altimore                         | 120   |  |  |  |  |
| Ba                         | permit. I<br>Depertm<br>Importar<br>any inju   |                   | 21. Signature of Funeral Service Licensee   | 2  | Name and Address of Facility  | LIAMS                               | F.S., P.K                        | 1.  |  |  |  |  |
|                            |  |                   | 23a. Part1. Enter the disease, or complica  |  | 0-130111651   | DAVIC                               | 0. / mp 2                        | Approximate                                     |  |  |  |  |
|                            |  |                   | shock, or heart failure. List only one  | cause on each line.  |   |                                     | ,                                | Interval Between<br>Onset and Death             |  |  |  |  |
| 1                          | Physician /Medical   |                   | disease or condition resulting in death)  | Mytherosciemonic (   | CANTIONASCULIS  | in other                            | ) 5                              |   |  |  |  |  |
|                            | /Medical<br>Examiner   |                   | Due to (or as a consequence of):  |  |   |                                     |                                  |   |  |  |  |  |
|                            |  | e .               | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): |  |   |                                     |                                  |   |  |  |  |  |
|                            | uted<br>ansit  | 두                 | Cause (Disease or injury  |  |   |                                     |                                  |   |  |  |  |  |
| Ć.                         | be executed<br>icien and<br>burial-transit   | Examiner          | that initiated events c. resulting in death) Last   | Due to (or as a consequence of):   |   |                                     |                                  |   |  |  |  |  |
| 8760,                      | icate be executed<br>physicien and<br>s the burial-transit   |                   | L d.  |  |   |                                     |                                  |   |  |  |  |  |
| 9                          | death certificate<br>e ettending phys<br>id for use as the   | Physician/Medical |   |  |   |                                     |                                  |   |  |  |  |  |
| Box                        | eath certific<br>ettending p<br>I for use as 1   | N/UE              | 23b. was decedent pregnant  | the state of the | Ectopic pregnancy   |                                     | 23d. Date of delive              | •   |  |  |  |  |
|                            |  | slcla             | in the past 12 months?<br>1 ☐ Yes 2 ☑ No  |  | Other (specify)   |                                     | Month                            | Day Year  |  |  |  |  |
| P.0.                       | et the de<br>by the e  | h                 | 9 Unknown   |  |   |                                     |                                  |   |  |  |  |  |
|                            | law requires thet the<br>es been signed by th<br>? Should be detache   |                   | Part II. Other significant conditions contr   | ibuting to death but not resulting in the ur   | nderlying cause given in Part I.  |                                     | co use contribute to the         |   |  |  |  |  |
| ord                        | w require<br>been si<br>should t   | ted               | BSOHMA  |  |   | 1 Tes                               | 2 No 3 Prob                      | ably 4 □Unknown                                 |  |  |  |  |
| ecc                        | e law r<br>hes be<br>je 2 sh   | P P               |   |  |   | 24a. Was an autopsy                 | 24b. Were auto                   | psy findings available<br>impletion of cause of |  |  |  |  |
| <u>=</u>                   | Page di  | Completed by      |   |  |   | performed<br>1 ☐ Yes 2 ☑            | death?                           | 2□ No   |  |  |  |  |
| /ita                       | ician: Th<br>certificete<br>rector, pag  | Be                | 25. Was case referred to medical examiner?  |  |   | (Check only one)                    |                                  |   |  |  |  |  |
| 7                          | Physi<br>this c  | မ                 | 10 193 2 NO   | spital:<br>1 ☐ Inpatient 2 🔀 ER/Outpatien  |   |                                     | 6 ☐Other (Specifi                | v)  |  |  |  |  |
| Ĕ                          | Attanding Physician:<br>r death.<br>actor: After this certific<br>by the funeral director,   | on:               | 27. Man or of Death 1 ✓ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year) 28b. Time of<br>Injury  | Work?   | 28d. Describe how in                | njury occurred                   |   |  |  |  |  |
| Sic                        | death<br>tor: ,<br>the f   | cat               | 2 Accident investigation 3 Suicide 6 Could not be   | On Discontinuo Athena for the  | M 1 Yes 2 No  | 006 1                               |                                  |   |  |  |  |  |
| Division of Vital Records, | in the   | Certification;    | 4 Homicide determined   | 28e. Place of Injury - At home, farm, strabuilding, etc. (Specify)   | вет, тастогу, опісе   | City or Town, St                    | and Number or Rura<br>ate)       | i Houte Number,                                 |  |  |  |  |
| J                          | apital<br>naral<br>filled  |                   | 29a. Certifier 1 Cartifying Physic  | cian: To the best of my knowledge, death   | a conversed at the time, data and alone                                       |                                     |                                  |   |  |  |  |  |
|                            | To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by   | edical            | (Check only 2 Medical Examine one)  | r: On the basis of examination and/or inv<br>and manner stated.  | estigation, in my opinion, death occurr                                       | ed at the time, date                | and place, and due to            | ated.<br>the cause(s)                           |  |  |  |  |
|                            | To the<br>Within<br>To the   | ₹.                | 29b. Signature and title of certifier   | 7.11   | 29c. License number   | 29d.                                | Date signed (Month,              | Day, Year)                                      |  |  |  |  |
| )                          | ->-0   |                   | Man Mag   | Usull vin  | OCME  | De                                  | cember 26,                       | 2005  |  |  |  |  |
|                            | V  |                   | 30. Name and addless of person who com  | pleted cause of death (Item 23a) (Type   | Print) 111 Penn Stree   | t Raltim                            | ore Marvi                        | and 21201                                       |  |  |  |  |
|                            | 5  |                   | MARGAMAN A.ICO  | DASU   | TIT TEIM DELEG  | t Dartill                           | orc, naryr                       | 21201   |  |  |  |  |
|                            | Sta  | ite               | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signature  |   |                                     |                                  |   |  |  |  |  |
|                            | Registr  | ar                | DEC 2 9 2005  | Breis H Book   | E)  |                                     |                                  |   |  |  |  |  |
| DH                         | MH 17 Rev 1/2  | 001               |   |  | 00  |                                     |                                  |   |  |  |  |  |

|               |  |                     | 1 - For<br>State<br>Registrar  |  | artment of Health and Me<br>rtificate of Death  | Reg. No.   | 42051   |
|---------------|--|---------------------|--|--|---|--|---|
|               | Physic<br>/Medi<br>Exami   | cal                 | Decedent's Name (First, Middle, La:     ALAN      ALAN  4a. Facility Name (If not institution, giv.)   | E  |   | 2. Date of Death<br>Month Day Year<br>December 25 900  | 5 11:30 PM  |
|               | Funeral<br>Director  | ICI                 | 5. Social Security Number 6. S<br>059-36-0316  | of Baltimore   | Bultimore Cit   | B. Date of Birth 9. 8.   | N/A<br>rthplace (State or Foreign<br>NY   |
|               | e Maryland<br>a-f ehow   | ctor                | Usual Residence of Decedent  10a. State 10b. County  MD BALTIN   | 10c. City, Town or L 10RE BALTI                                      |   |  | 10d. Inside City Limits 1 ☐ Yes 2√ No   |
|               | leath with the   | by Funeral Director | 10e. Street and Number  8807 HOWARD FOF  11. Marital Status  |  | 10f. Zip Code 21208 Was Decedent of Hispanic Origin? (Speci   | 10g. Citizen of What C  U.S.A.  fy Yes or No-  14. Race - Arr                                |   |
| 9600          | within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show the Madical Examinar must be notified at | d by Fun            | 1 Never Married 2 Married 3 Widowed 4 Divorced   | 1 ☐ Yes 2 ☐ No<br>If Yes, Give X<br>Year or Dates:                   | Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri  | Specify:   | ite, etc.<br>WHITE  |
| 21215-0036    | filed within 72 Hygiene.   | Completed           | 15. Decedent's Et<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | (Give<br>life.   | ident's Usual Occupation is kind of work done during most of work done during most of working DO NOT use retired)  STMENT ADVISOR | FINANCE  | s/Industry  |
| Maryland      | should be file<br>nd Mental Hy<br>s marked oth<br>umatic event   | To Be               | 17. Father's Name (First, Middle, Last) DAVID  19a. Informant's Name/Relationship (  | CHESKI   |   |  | KIRSH<br>Zin Code)  |
| Baltimore, Ma | 1 and 2<br>Health a<br>tam 27 is   |                     | BARBARA CHESKIN /  20a. Method of Disposition  1  Burial 2 Cremation 3 C  4 Donation 5 Other (Specific   | WIFE 8807  Removal from State 20b. Place of Dispricemetery, cre      | HOWARD FOREST LANE position (Name of matory or other place)   | - BALTIMORE, MD  | 21208<br>r Town, State  |
| Balti         | permit. Pages<br>Department of<br>Important; If it<br>eny injury or o  |                     | 21. Si valura / Funeral Service Cer  | Mgu 8  | 2. Name and Address of Facility SOL<br>1900 REISTERSTOWN RO   | LEVINSON & BROS.<br>AD - PIKESVILLE,   | , INC.<br>MD 21208  |
|               | Physician<br>/Medical<br>Examiner  |                     | Immediate Cause (Final disease or condition resulting in death)  | Due to (or as a consequence of).                                     | aged Cancer   | espiratory arrest,   | Approximate Interval Batween Onset and Death Unknown  |
| 68760,        | tificate be executed g physicien and as the burial-transit   | edical Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):  C                                  |   |  |   |
|               |  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No   |  | □Ectopic pregnancy<br>□ Other (specify)   | 23d. Date of de<br>Month   | livery<br>Day Year  |
| Records, P    | requir   | Completed by P      | Part II. Other significant conditions o  | ontributing to death but not resulting in the u                      | inderlying cause given in Part I.   |  | o the cause of death?  robably 4 Dinknown  utopsy findings available completion of cause of |
|               |  | Be Com              | 25. Was case referred to medical examiner?   |  | 26. Place of Death (  | 1 Yes 2 No 1 Yes   |   |
| Division of \ | ding Phys  | Certification: To   | 1 Yes 2 No  27 Manner of Death  1 Natural 2 Accident 3 Suicide 6 Could not be  |  | 1 28c. Injury at Work? M 1 □ Yes 2 □ No   | 5 Residence 6 Other (Spet)  d. Describe how injury occurred                                  |   |
| Div           | To the Hospital or Attentwithin 24 hours after death To the Funeral Director: cumpletely filled in by the                              | al Certif           | 4 Homicide determined  29a. Certifier 1 Certifying Ph  | building, etc. (Specify)  vsician: To the best of my knowledge, deat | h occurred at the time, date and place, and   | Location (Street and Number or R<br>City or Town, State)  d due to the cause(s) and manner a | Sector  |
|               | To the Ho<br>within 24 I<br>To the Fu<br>c. mpletely   | Medical             | 29b. Signature and title of certifier  | niner: On the basis of examination and/or in and manner stated.      | vestigation, in my opinion, death occurred  29c. License number   | at the time, date and place, and du  | e to the cause(s)   |
| 10            | 7  |                     | 30. Name and address of person who see the R.  31. Date filed (Month, Day, Year)   | completed cause of death (Item 23a) (Type,                           | Print) West Leter   | Beltina M  | 25 2005   |
| DH            | Sta<br>Regist<br>MH 17 Rev 1/2   | rar :               | DEC 2 9 2  |  | Soli V  | -  |   |

|                |   |                | 1_ For   | State of M                              |                        | d / Depa                     | artmer      | nt of H                   |                  |            | •                       | ygien                         | <b>0</b> 05                           | 42052  |
|----------------|---|----------------|--|---|------------------------|------------------------------|-------------|---------------------------|------------------|------------|-------------------------|-------------------------------|---------------------------------------|--|
|                | . Also  | W.             | Registrar  1. Decedent's Name (First, Middle, L.   | actl                                    |                        | Cel                          | lilical     | e or i                    | Dealli           |            | 2 Data of C             | Reg. N                        | 0.                                    |  |
|                | Physici   | an             | Fmily Theresa  | Daniels                                 |                        |                              |             |                           |                  | i          | 2. Date of D<br>Month   | Da                            |                                       | 3. Time of Death                                   |
|                | /Medi   |                | 4a. Facility Name (If not institution, gi  |   | -)                     |                              | 4h City     | Town or                   | Location o       |            | Decemb                  |                               | 26, 2005<br>c. County of Deal         | 1:05p M  |
|                | Examir  | ier            |  | Hospice                                 | ,                      |                              |             | imor                      |                  | n Dodin    |                         |                               | o. County of Deal                     |  |
|                | Funeral   | 40             | -  |   | ge (In yrs. la         | ast birthday)                | If Unde     | r 1 Year                  | If Under 2       |            | 8. Date of B            | irth                          | 9. Birt                               | hplace (State or Foreign                           |
| F:             | Director  |                | 392-18-5870  | 1□M 2 <b>X</b> 2F                       | 84                     | Yrs.                         | Months      | Days                      | Hours            | Min.       | (Month, L<br>Decembe    | <sup>Day, Year</sup><br>r 23. | Co                                    | Consin   |
|                | pc ,  |                | Usual Residence of Decedent  |   |                        |                              |             |                           |                  |            |                         |                               | ,,,,,,,                               | 301101111  |
| 1              | shov  | _              | 10a. State 10b. County   |   | TOc. City              | , Town or Lo                 | cation      |                           |                  |            |                         |                               |                                       | 10d. Inside City Limits                            |
| 0,             | 88a-f   | Directo        | Maryland Howard  |   | Elk                    | ridge                        |             |                           |                  |            |                         |                               |                                       | 1 ☐ Yes 2√∑ No                                     |
| S              | with the  | 급              | 10e. Street and Number   |   |                        |                              | 10f. Zip    | Code                      |                  |            |                         |                               | itizen of What Co                     | ountry?  |
| 6              | death with the Maryland<br>ms 23a or 28a-f show<br>rmust be notified at   | Funeral        | 5854 Washington  | Blvd. 12. Was Decedent                  | t Consin III S         | 2 42 1                       | Man Davi    | 210                       | · -              | -:-0./0    | 1                       | U.S                           |                                       |  |
|                | iter d  | Ë              | 11. Marital Status  1√□ Never Married 2□ Married   | Armed Forces                            | ?                      |                              | t Yes, spe  | cify Cuba                 | n, Mexican       | , Puerto R | rfy Yes or Nican, etc.) | 10-                           | 14. Race - Ame<br>Black, White        |  |
| 336            | hours after<br>tural, or ite  | by             | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:          | -                      |                              | 1 ☐ Yes     | 2 <b>X</b> No             | Specify:         |            |                         |                               | Specify:                              |  |
| 21215-0036     | 72 hours after death with the Marylan<br>*natural; or items 23a or 28a-f show<br>idical Examinar mad be notified at | Completed      | 15. Decedent's E   | ducation                                |                        | 16a. Dece                    | dent's Usu  | al Occupa                 | ation            |            |                         | 16b. h                        | (ind of Business/                     | nite<br>Industry                                   |
| 21,5           | within 7<br>ene.<br>than *n   | ple            | (Specify only highest gi<br>Elementary/Secondary (0-12)  | College (1-4or                          | 5+)                    | life.                        | NOT u       | ork done d<br>ise retired | during most<br>) | of working | 9                       |                               |                                       | •  |
| 2              | be filed within 72 ho<br>ital Hygiene.<br>id other than "natur<br>avant, Ira Medical                                | Con            | 8  |   | -                      | Resta                        | ırant       | . Ow                      | ner              |            |                         | Foo                           | d Servi                               | ce   |
| nd             | be filed<br>tal Hygi<br>d other<br>avent, I   | Be (           | 17. Father's Name (First, Middle, Las  | t)                                      |                        |                              |             |                           | 18. Mothe        | r's Name   | First, Middl            | e, Maidei                     | Sumame)                               |  |
| yla            | should be and Mental I a marked o   | ဥ              | Archie Missinne  |   |                        |                              |             |                           | Mary             | Mis        | sinne                   | :                             |                                       |  |
| Maryland       | 2 sho   |                | 19a. Informant's Name/Relationship   |   |                        |                              |             |                           |                  |            |                         |                               | or Town, State, Z                     |  |
|                | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic   |                | Daniel C. Daniels  | - son                                   | Jack Br                | 5219                         | []che       | ster                      | Rd.,             |            |                         | -                             | , MD 210                              |  |
| 10             | ges 1 ar<br>it of Hea<br>if item<br>or other  |                | 20a. Method of Disposition 1 Burial 2 Cremation 3  | ☐Removal from State                     |                        | ace of Dispo<br>metery, cren | natory or o | me or<br>other place      |                  | Da         |                         |                               | ocation - City or                     |  |
| ţ              | t. Pa<br>rtmen<br>rtant:  |                | 4 Donation 5 Other (Special  |   | Metro                  | Cremat                       | -           |                           |                  |            | -2005                   | Cato                          | nsville,                              | Maryland   |
| Baltimore,     | permit. Pages of Department of Important: If Ite any injury or of once.   |                | 21. Signature of Funeral Service Lice  |   |                        | -                            | -           |                           | s of Facility    |            | ral E                   | omo                           | at MMP,                               | TNC  |
|                |   |                | 23a. Part1. Enter the disease, or conshock, or heart failure. List only  | nolications that cause                  | d the death            | 72                           | 250 W       | ashi                      | ngton            | Blvc       | l., El                  | krid                          | ge, MD                                | 21075  |
|                |   |                | shock, or heart failure. List only   | one cause on each                       | line.                  | . DO HOL WILL                | er the mot  | _( —                      | y, such as c     | cardiac or | respiratory             | arrest,                       |                                       | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician<br>/Medical   |                | disease or condition resulting in death)   | _a50                                    | mile                   |                              | nen         | 4.9                       |                  |            |                         |                               |                                       | unknow   |
| *              | Examiner  |                |  | Due to (or as                           | s a consequ            | ence of):                    |             |                           |                  |            |                         |                               |                                       |  |
|                | \$ 1  | er             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | b. Due to (or as                        | s a conseque           | ence of):                    |             |                           |                  |            |                         |                               |                                       |  |
|                | eath certificate be executed attending physicien and for use as the burial-transit                                  | Examiner       | Cause. Enter Underlying Cause (Disease or injury that initiated events   |   |                        |                              |             |                           |                  |            |                         |                               |                                       |  |
| o,             | be executed<br>icien and<br>burial-transit  |                | resulting in death) Last   | Due to (or as                           | s a conseque           | ence of):                    |             |                           |                  |            |                         | ····                          |                                       |  |
| 1760,          | ite be<br>iysicii<br>ne bu  | Ical           | (  | d                                       |                        |                              |             |                           |                  |            |                         |                               |                                       |  |
| 89             | ng pt<br>ng pt  | Physician/Medi | IF FEMALE:   |   |                        |                              |             |                           |                  |            |                         |                               |                                       |  |
| Вох            | ath ce<br>ttendi  | an/I           | 23b. Was decedent pregnant<br>in the past 12 mopths?   | 23c. If yes, outcome<br>1 ☐ Live birth  | of pregnan<br>2  Fetal |                              | Ectopic p   | regnancy                  |                  |            |                         | Ì                             | 23d. Date of deli                     |  |
| 0.             | the a   | sic            | 1 Yes 2 No   | 4□Pregnant a<br>9□ Unknown              | at time of dea         | ath 5□                       | Other (sc   | pecify)                   |                  |            |                         |                               | Month                                 | Day Year   |
| 0              | that the dead by the detached   | P <sub>P</sub> | Part II. Other significant conditions  | contributing to dooth I                 | but not sonul          | tion in the                  |             |                           | - In Book        |            | 02- Did                 |                               |                                       |  |
| Vital Records, | se us   | l by           | Turris official offic | sommouning to death t                   | Dat Hot 16sul          | ung in the ur                | idenying d  | ause give                 | in in Pari i,    |            |                         |                               |                                       | the cause of death?                                |
| Ö              | w requir<br>been si<br>should   | Completed      |  |   |                        |                              |             |                           |                  |            | -                       | 103 2                         | UE 140 3                              | ——————————————————————————————————————             |
| Rec            | has<br>ge 2   | mp             |  | p                                       |                        |                              |             |                           | <del></del>      | *          |                         | s an<br>opsy<br>ormed?_       | 24b. Were aut<br>prior to c<br>death? | topsy findings available ompletion of cause of     |
| <u>_</u>       |   |                | 05.14  |   |                        |                              |             |                           |                  |            | 1 Yes                   | 2 1 No                        |                                       | 2 🗆 No   |
| ₹              | ysician:<br>is certific<br>director,  | o Be           | 25. Was case referred to medical examiner?   | Hospital:                               |                        |                              |             | Othe                      |                  |            | Check only              |                               |                                       |  |
| o              | Phys<br>r this<br>ral di  | <b>—</b>       | 1 Yes 2 No  27. Manner of Death  | 1 Inpati                                |                        | R/Outpatien<br>28b. Time of  |             | /A                        | 4 🗆 Nur          | 1          | 5 ☐ Res<br>d. Describe  |                               | 6 Tother (Spec                        | ify)   |
| o              | ding Phy<br>th.<br>After thi<br>funeral o   | tlor           | 1 Natural 5 Pending<br>2 Accident investigation  | (Month, Da                              | ay Year)               | Injury                       | м           | 28c. Injury<br>Work       | ?<br>′es 2⊟N     | ,          | d. Describe             | now inju                      | ry occurred                           |  |
| Division of    | il or Attending Physician:<br>after death.<br>Director: After this certific<br>d in by the funeral director.        | flca           | 3 Suicide 6 Could not b  | De 290 Place of In                      | jury - At hon          | ne, farm, stre               |             |                           |                  |            | f. Location             | Street ar                     | nd Number or Ru                       | ral Route Number.                                  |
| Ö              | after<br>after<br>Dire  | Certification: | 4 Homicide   | building, e                             | tc. (Specify)          |                              |             | , 011100                  |                  |            | City or To              | wn, State                     | 9)                                    | ar riodie redinber,                                |
|                | To the Hospital or Attenwithin 24 hours after deati<br>To the Funeral Director:<br>completely filled in by the      | - E            | 29a. Certifier 1 Certifying Pl   | hysicien: To the best                   | of my know             | ledge, death                 | occurred    | at the tim                | e, date and      | place, an  | d due to the            | cause(s                       | ) and manner as                       | stated.  |
|                | n 24<br>n 24<br>he Fi   | edica          | (Check only 2 Medical Exa  | miner: On the basis of<br>and manner st | of examinatio          | on and/or inv                | estigation  | , in my op                | inion, death     | h occurred | at the time.            | date and                      | d place, and due                      | to the cause(s)                                    |
|                | To the<br>within:<br>To the<br>comple   | Σ              | 29b. Signature and title of certifier  | /                                       | _                      |                              | 290         | . License                 | number           |            |                         | 29d. Da                       | te signed (Month                      | , Day, Year)                                       |
| •              |   |                | David L  | 12. ME                                  |                        |                              |             |                           | 603              |            |                         | De                            | 27,2                                  | 2005   |
|                | 20  |                | 30. Name and address of person who   |   |                        | 23а) (Туре, І                |             |                           |                  |            |                         |                               |                                       | * 1  |
|                | ′) ¯  |                | Devid L. Kno X<br>31. Date filed (Month, Day, Year)  | q w.                                    | hahe                   | 23a) (Type, I                | Bul         | time                      | u r              | NY         | 21716                   | 7-12                          | 03                                    |  |
|                | Sta<br>Registr  | 200            | DEC 2 9 2005   | 32. Hegisti                             | ars signatu            | 10546                        | 1           |                           |                  |            |                         |                               |                                       |  |

05-08769 Michael Joseph Davis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ac <sub>1</sub>     | . oosep  | ,11            | 1 - For State Registrar   | State of M  | laryland  | / Depa                          | artment o                        | of Health<br>of Death                          | and M                     | lental H                           | ygiene                   | 000   | 4205  | 3              |
|---------------------|--|----------------|---|---|---|---------------------------------|----------------------------------|--|---------------------------|------------------------------------|--------------------------|---|---|----------------|
| 6                   | Physic   |                | Decedent's Name (First, Middle)   |   | Tono  | ah D                            |                                  |  |                           | 2. Date of December                | Death                    |   | 3. Time of D                                  | Death<br>PM    |
|                     | /Medi<br>Examii  |                | 4a. Facility Name (If not institution,<br>Eastern Avenue a  | -   | )   | ם זום                           |                                  | wn, or Location<br>Essex                       |                           | Decem                              | 4c.                      | County of Death                                 | 1   |                |
|                     | Funeral<br>Director  |                | 516-34-1978   | 6. Sex 7. A   | ge (In yrs. last                                | birthday)<br>Yrs.               | If Under 1 Y<br>Months D         |  |                           | 8. Date of E<br>(Month, L<br>Jan21 | Birth<br>Day, Year)      | 9. Birtl<br>Co                                  | nplace (State or I<br>untry)                  | Foreign        |
|                     | Maryland -f ehow   | tor            | Usual Residence of Decedent   | imore   | 10c. City, T                                    | own or Lo                       |                                  |  |                           |                                    |                          |   | 10d. Inside City 1 ☐ Yes 2                    |                |
| :                   | n with the<br>23a or 28a<br>at be not  | ai Director    | 10e. Street and Number 946 Middlese   | x Road  |   |                                 | 10f. Zip Co                      | de<br>221                                      |                           |                                    | 10g. Citi                | zen of What Co                                  |   |                |
| 036                 | permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Heath and Menial Hygiene. Department of Heath and Menial Hygiene. Important: If term 27 is marked other then "natural", or items 23s or 28s-f show eny injury or other traumatic event. I'm Medical Examinar must be invitted at once. | by Funerai     | 11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced   | 12. Was Decedent Armed Forces' d 1 X Yes 2 If Yes, Give Year or Dates:  | ?   |                                 | Vas Decedent<br>Yes, specify     | of Hispanic Or<br>Cuban, Mexica<br>No Specify: |                           | ecity Yes or N<br>Rican, etc.)     |                          | 14. Race - Amer<br>Black, White<br>Specify: Wh: | , etc.  |                |
| Maryland 21215-0036 | within 72 ho<br>lene.<br>then "natur<br>ne Medical   | Completed      | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)  | grade completed) College (1-4or   |   | (Give<br>life. L                | OO NOT use re                    | one during mos                                 | st of worki               | ng                                 | 16b. Kii                 | nd of Business/I                                |   |                |
| yland 2             | should be filed vind Mental Hygie<br>s marked other t<br>umatic event. In  | To Be C        | 17. Father's Name (First, Middle, L<br>Carl Davis   |   |   | Fild                            | ineer                            |  |                           | (First, Middle)                    | e, Maiden                |   |   |                |
|                     | 1 and 2 sho<br>Health and<br>Pm 27 is m<br>ther traum  |                | 19a. Informant's Name/Relationshi Doris Davis/ 20a. Method of Disposition   | Wife  | _   |                                 |                                  |  |                           |                                    |                          | Town, State, Zi<br>221                          |   |                |
|                     | permit. Pages Department of h Important: if its eny injury or of   |                | 1 X Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature) of Funeral Service □  | ecify)  | Sacre   | edHe                            |                                  | Jesus  | 12/3                      |                                    | Dunc                     | dalk, M   | ID  |                |
| P                   | hysician /Medical Examiner   |                | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List o<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)         | _a_ Multip  | d the death. Done.  ole Injourned a consequence | o not ente                      | or the mode of                   | e Aven   | ue B                      | Baltim                             | iore.                    | MD 21   | Approximate Interval Betwee Onset and Dea     | en             |
| . Box 68/60,        | cate be executed<br>physicien and<br>the burial-transit  | dical Examiner | Sequentially list conditions, # any Lacong to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | с.  | a consequence                                   |                                 |                                  |  |                           |                                    |                          |   |   |                |
| פַ כ                | ache ache  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown | 2 Fetal dea                                     |                                 | Ectopic pregna<br>Other (specify |  |                           |                                    | 2:                       | 3d. Date of deliv                               | ery<br>Day Yea                                | ır             |
| Records, P          | should be delt   | by             | Part II. Other significant condition  | s contributing to death b   | ut not resulting                                | in the un                       | derlying cause                   | given in Part I.                               |                           |                                    | tobacco us               |   | ne cause of death                             |                |
| The law             | ete has b  | e Completed    | 25. Was case referred to medical  |   |   |                                 |                                  |  | -                         | 1 ☐ Yes                            | psy<br>ormed?<br>2020No  | prior to co<br>death?                           | psy findings ava<br>mpletion of cause<br>2 No | ilable<br>e of |
| Or VITA             | al this  | 10 B           | examiner?  1XX es 2 No  27. Manner of Death   | Hospital:   |   |                                 | 3[] 00A                          | Other: 4 Nu                                    | rsing Hom                 |                                    | idence 6                 | Other (Specif                                   | SCENE   |                |
| DIVISION            | 0 5 -  | Certification: | 1 Natural 5 Pending investiga 3 Suicide 6 Could no determin   | be One Place of lai   | ury - At home,                                  | Time of Injury  LU farm, street | M 1                              | njury at<br>Work?<br>I⊡ Yes 2∭21<br>ce         | 2                         | City or To                         | Greet and                |   | 51.5  | 771134         |
| The Hospitei        | within 24 hours effe<br>To the Funeral Discompletely filled in   | Medicai        | one)  | Physician: To the best<br>aminer. On the basis of<br>and manner sta     | examination a                                   | ge, death<br>and/or inve        | istigation, in m                 | y opinion, deat                                | d place, ar<br>h occurred | nd due to the<br>d at the time,    | cause(s) a<br>date and p |   | 1   | 11.7           |
| 17                  | 9  |                | 29b. Signature and title of certifier  20b. Signature and title of certifier  30. Name and address of person wh   | 10000000000000000000000000000000000000                                  | eath (Item 23a                                  | ) (Type. P                      | rint)                            | O.C.M  |                           |                                    | Dece                     | signed (Month,<br>mber 27,                      | 2005  |                |
| 10                  | Sta  |                | 31. Date filed (Month, Day, Year)   | AH 32. Registra   | ar's Signature                                  | 111                             | Penn St                          | treet,   | Balti                     | imore,                             | Mary                     | land 212  | .01   |                |
| DHMH                | Registra   |                | DEC 2 9   | 2005  | w the   | for                             | de                               |  |                           |                                    |                          |   |   |                |

| evin Max<br>5-08681   | clowe:  | 11                 | Dunnings Plea Unpend item#2  | ise Type or P                          | rint in E                                      | Black Inc                                   | delible lnk   | Ensure A                                  | II Copie:                           | s Are                  | Legible.                                  |  |
|---|---|--------------------|--|--|--|---|---|---|-------------------------------------|------------------------|---|--|
| n   |   |                    | For State Registrar  | State of                               | iviai ytai                                     | Cer   | tificate of   | Death                                     | vicinarii                           | Reg: N                 |   | 4205                                     |
|   |   |                    | Registrar     Decedent's Name (First, Midd   | le, Last)                              |  |   |   |   | 2. Date of D                        | eath                   | -   | 3. Time of De                            |
| P   | Physicia  |                    |  | 1AXLOWELL                              | DUNNI  | NGS   |   |   | Decemb                              | oer 2                  | 2×3, 2005                                 | 10:47                                    |
|   | /Medic<br>Examin  |                    | 4a. Facility Name (If not institution  | n, give street and numb                | ber)   |   | 4b. City, Town, o                                   | or Location of Death                      | 1                                   |                        | c. County of Deat                         |  |
|   | E.AGIIIII   | •                  | 16028 English  | Oak Avenue,                            | Apart  | ment E                                      | Bowie   |   |                                     |                        | Prince G                                  |  |
|   | uneral<br>irector   |                    | 5. Social Security Number 224-13-4792  | 6. Sex 7<br>1 1 M 2 ☐ F                | . Age (In yrs.<br>43                           | last birthday)<br>Yrs.                      | If Under 1 Year<br>Months Days                      | If Under 24 Hrs.<br>Hours Min.            | 8. Date of B<br>(Month, D           |                        |   | hplace (State or F<br>buntry)<br>ginia   |
| D B   | >   |                    | Usual Residence of Decedent<br>10a. State 10b. County  | ,                                      | 10c Cit  | y, Town or Lo                               | cation  |   |                                     |                        |   | 10d. fnside City I                       |
| e Maryla  | rotified at   | ctor               | Virginia   |  |  | ewport                                      |   |   |                                     | ,                      |   | X□Yes 2                                  |
| with th   | 23s or 28   | Dire               | 10e. Street and Number 59 Huxley Pl  | lace                                   |  |   | 10f. Zip Code                                       | 3606                                      |                                     |                        | U.S.A.                                    | ountry?                                  |
| er dea  | or items 23   | / Funeral Director | 11. Maritaf Status 1 □ Never Married 2 □ Mar   | 12. Was Deced Armed Ford Tried 1 Yes 2 | es?<br>! □ No                                  | 4   | Vas Decedent of H                                   | Hispanic Origin? (Span, Mexican, Puerto   | pecify Yes or No Rican, etc.)       | lo-                    | 14. Race - Ame<br>Black, Whit<br>Specify: |  |
| <b>6003</b>   | turei',   | ed by              | 3 Widowed 4 Divorced   | Year or Dat                            | es:  |   |   | pation                                    |                                     | 16b.                   | Kind of Business/                         | Industry                                 |
| 1215-<br>within 72<br>ene.  | then "na  | Completed          |  | College (1-4                           | for 5+)  | İ   | kind of work done<br>OO NOT use retire<br>curity    | pation<br>during most of wor<br>d)        | king                                |                        | ecurity (                                 | •  |
| Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours alt Depertment of Health and Mental Hygiene. | To H  | To Be Co           | 17. Father's Name (First, Middle,  |  | Dun  | nings                                       |   | 18. Mother's Nam<br>Barbara               | ne (First, Middl                    | e, Maide               | Yancey                                    |  |
| Maryla  | 27 is mar<br>ir traumat                                     |                    | 19a. Informant's Name/Relation. Cassandra B.   | ship (Type, Print)<br>Dunnings (       | Wife)  | 19b. Mailir<br>59 H                         | g Address (Street<br>uxley Pla                      | and Number or Ru<br>ace, Newp             | ort Nev                             | ber, City<br>VS ,      | or Town, State, 2<br>Va. 2360             | Zip Code)<br>G                           |
| MOre,   | Important: If item 27 i<br>eny injury or othar tra<br>gnce. |                    | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)   |  | ate T  | Place of Dispo<br>cemetery, crem<br>nornros | sition (Name of<br>natory or other pla<br>Se Cemete | ery 12/29                                 | Date<br>9/05                        |                        | Location - City or<br>unton, V            |  |
| alti<br>emit.   | porta<br>ny inju  |                    | 21. Signature of Funeral Service   | Licensee                               |  | / 22  | Mc Cull   | ry o'Facitynia                            | ak Fune                             | ral                    | Home P.A                                  |  |
| <b>—</b> % & & & & & & & & & & & & & & & & & &  | E 2 9   |                    | 23a. P Enter the disease, of ock, or heart failure. Lis  | 8100                                   | m  |   | 130 E.  | Fort Ave                                  | . Balti                             | more                   | , Md. 21                                  | .230<br>Approximate                      |
| /Mc<br>Exa  | cician edical edical miner                                  | ai Examiner        | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. — Due to (o                         | ras a conseq                                   | uence of):<br>uence of):                    | to rocar r  | Myocardial 1                              | r I I I O S I S                     |                        |   |  |
| Division of Vital Records, P.O. Box 68760 for Attending Physician: The law requires that the death certificate be effer death.    | by the ettending physicien<br>ached for use as the buris    | Physician/Medical  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |  | th 2 ☐ Feta<br>ntattime of d                   | Ideath 3                                    | Ectopic pregnanc                                    | у   |                                     |                        | 23d. Date of del<br>Month                 | ivery<br>Day Yea                         |
| ds, P.C   | De o  | þ                  | Part II, Other significant condit  | ions contributing to dea               | ith but not res                                | ulting in the u                             | nderlying cause gr                                  | ven in Part I.                            |                                     | tobacco                | . /                                       | the cause of dea                         |
| Recor   | rificete hes been si<br>dor, pege 2 should                  | Completed          | V  |  |  |   |   |   | 24a. Wa<br>aut<br>per<br>1 Yes      | opsy<br>formed?        | prior to<br>death?                        | utopsy findings ava<br>completion of cau |
| ital  | # o   | 0                  | 25. Was case referred to medica  | al                                     |  |   |   | 26. Pface of Dea                          |                                     |                        |   |  |
| Y Y   | direc   | ToB                | examiner? 1 Yes 2 No   | Hospital: 1 ☐ In                       | patient 2                                      | ER/Outpatien                                | t 3 DOA   | her: 4 Nursing H                          |                                     |                        | 6XOther (Spe                              | cifyat scer                              |
| ion of  | fter t  |                    | 27. Manner of Death  1 Natural 5 Pendi 2 Accident invest   | 28a. Date of<br>(Month<br>ligation     | Injury<br>, <i>Day</i> Yea <i>r)</i>           | 28b. Time of<br>Injury                      | Wo  | ry at<br>rk?<br>] Yes 2 ☐ No              | 28d. Describe                       | how inj                | ury occurred                              |  |
| Divisio   | i Directo<br>d in by th                                     | Certification:     | 3 Suicide 6 Could determ   | minor 289. Place C                     | of Injury - At h<br>g, etc. <i>(Speci</i> i    | ome, farm, str<br>fy)                       | eet, factory, office                                |   | 28f. Location<br>City or T          |                        |   | ıral Route Numbe                         |
| E Hospital  | To the Funerel Director: A completely filled in by the fu   | Medicai C          | 29a. Certifier  (Check only one)  1 Certifyi 2 Medica  | ing Physician: To the base and manner  | pest of my kno<br>sis of examina<br>er stated. | owledge, death                              | occurred at the ti<br>restigation, in my            | me, date and place<br>opinion, death occu | , and due to th<br>rred at the time | e cause(<br>e, date ar | s) and manner as<br>nd place, and due     | stated.<br>to the cause(s)               |
| To the within 2   | To th<br>comp   | Me                 | 29b. Signature and title of certifi  | er \ \                                 |  | _   | 29c. Licen:   | se number                                 |                                     | 29d. D                 | ate signed (Mont                          | h, Day, Year)                            |
|   |   |                    | 30. Name and address of person   | Thelle                                 | ull V  | m 23a) (Tune                                |   | O.C.M.E.                                  |                                     | Dec                    | cember 24                                 | +, 2005                                  |
| 0   | Ô   |                    | 1111111014   | n 1 (a)                                | RELL   | 111   | Penn Sti  | reet, Bal                                 | timore,                             | Mar                    | ryland 21                                 | 1201                                     |
|   | Sta<br>Registr  |                    | 31. Date filed (Month, Day, Year DEC 2. 9  | 2005                                   | gistrans Signa                                 | ture Sol                                    | we will   |   |                                     |                        |   |  |

Scott Daniels 05-08687 crn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#2a,27,26-f,pentf.(851,1/30/06 II

|   |                      | 1 - For<br>Stata<br>Registrar  | State of Maryla  | nd / Départ<br><i>Certi</i> i             | ment of F<br>ficate of                                 | lealth and M<br>Death  |                                      | iene () ()                               | 15                      | 4205                                      |
|---|----------------------|--|--|---|--|--|--------------------------------------|--|-------------------------|---|
| Physic<br>/Medi   |                      | Decedent's Name (First, Middle, La SCOTT   | January Dar  | niels                                     |  |  | 2. Date of Deat<br>Month<br>Decembe: | Day                                      | .005                    | 3. Time of Death                          |
| Examir<br>Funeral<br>Director   | ner                  |  | eet, Apartment   | 133<br>. last birthday)                   | b. City, Town, o  Raltin f Under 1 Year tonths Days    | DEC II Under 24 Hrs. Hours Min.  | 8. Date of Birth<br>September        | 4c. County                               | N/A                     | lace (State or Fore                       |
| death with the Maryland me 23a or 28a-f ehow  | ctor                 | Usual Residence of Decedent  10a. State 10b. County  Maryland N/A  |  | ity, Town or Locat                        | ion  |  |                                      |  | 11                      | 0d. Inside City Lim                       |
| th with th  | al Director          | 3501 Saint Paul S  | treet  |   | 10f. Zip Code<br>21218                                 |  | 10                                   | Og. Citizen of W                         | Vhat Coun               | try?                                      |
| urs after dea<br>al', or iteme  | by Funeral           | 11. Marital Status  1 XX lever Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 Tyes 2XXVIO<br>If Yes, Give<br>Year or Dates:   | II Ye                                     | Decedent of H<br>es, specify Cuba<br>Yes               | ispanic Origin? (Spe<br>in, Mexican, Puerto<br>Specify:  | ecify Yes or No-<br>Rican, etc.)     | 14. Race<br>Blace<br>Specify:            | - Americ<br>k, White, e | an Indian,<br>atc.<br>Ihite               |
| be filed within 72 hours after death v<br>tall Hyginan and other than a 23s<br>d other than a ture!, or iteme 23s<br>event, The Medical Examiner must | Completed            | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   | ducation   | (Give kind<br>life. DO                    | 's Usual Occupi<br>d of work done o<br>NOT use retired | ation<br>during most of worki<br>)   | ng                                   | 6b. Kind of Bu                           | siness/Ind              | lustry                                    |
| 2 should be filed on and Mental Hygie to marked other teumatic event, the   | To Be C              | 17. Father's Name (First, Middle, Last, Derick January Da  | niels  |   |  | 18. Mother's Name<br>Elizab  | eth Blal                             | faiden Sumame                            |                         |   |
| 0 =   |                      | 19a. Informant's Name/Relationship (Elizabeth Blalock 20a. Method of Disposition   | Daniels Mothe  | er 3 Caro                                 | lina Me  |  | 103 Cha                              | City or Town, Spel Hill Oc. Location - C | North                   | Carolina                                  |
| permit. Peges 1 an<br>Department of Heel<br>Important: If Item 2<br>eny injury or other<br>ance.  |                      | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 5 other (Specification) 5 other (Specificatio | ure  | enMount Cer                               | netery   | 12/29/0  | 05                                   | Baltimore                                | e, Mar                  | yland                                     |
| 89 6 8  |                      | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only   | Menakes  plications that caused the dear   |   |  | 6500 York  | k Road Bal                           | timore, M                                |                         |   |
| death certificate be executed  Solution and  If of or use as the buriat-transit   | ın/Medicai Examiner  | Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant   | Due to (or as a consect b.  Due to (or as a consect c.  Due to (or as a consect d.  23c. If yes, outcome of pregnations of pre | juence of):                               |  |  |                                      | 23d. Date                                | ol deliver              |   |
| that the deatred by the atte  | by Physician/M       | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown  | leath 5 Oth                               | opic pregnancy<br>ner (specify)                        |  |                                      | Mont                                     |                         | Day Year                                  |
| w requires that be some signed is should be det   |                      | Part II. Other significant conditions c  | ontributing to death but not res   | ulting in the under                       | lying cause give                                       | n in Part I.   |                                      | 11                                       |                         | cause of death?                           |
| ne la<br>ete hes<br>page 2  | e Completed          | 25. Was case referred to medical   |  |   |  |  |                                      | od? de                                   | ath2                    | sy findings availal<br>pletion of cause o |
| his lai   | Certification: To Be | examiner?  | 28e. Place of Injury - At he building, etc. (Specification)  | 28b. Time of Fix<br>6:35 P                | 28c. Injury<br>Work                                    | at 2 Nursing Homes 2 Nursing H |                                      | ce 6 Other injury occurred  fell on i    | Sub<br>ice              | ject has                                  |
| 24 hours  | edical C             | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exam  | vsician: To the best of my kno<br>iner: On the basis of examina<br>and manner stated.  | wledge, death occ<br>tion and/or investig | urred at the time<br>gation, in my opi                 | a, date and place, and nion, death occurred  | and along the sta                    | se(s) and manr<br>e and place, an        | ner as stated           | ed.<br>ne cause(s)                        |
| 7.  |                      | 29b. Signature and title of certifier  | Ushel mo   |   |  | number   |                                      | I. Date signed (                         |                         |   |
| Pra   |                      | 30. Name and address of person who o   | KOREU  | 111 Per                                   |  | t, Baltim  | nore, Man                            | ryland 2                                 | 21201                   |   |
| Stat<br>Registra  |                      | 31. Date filed (Month, Day, Year)  DFC 2 9 2005  | Registrar's Signa  | ture                                      |  |  |                                      |  |                         |   |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,22a-f, perME,032,271/06 IT

| TAIN T                     | DOWNET   | O.             | State of Maryland / Departme   | ent of Health and I<br>ate of Death                                     |   | iene<br>og. No.   | 12056  |
|----------------------------|--|----------------|--|---|---|---|--|
|                            | Physic<br>/Medi  |                | 1. Decedent's Name (First, Middle, Last)  Gary Lee Downey, Jr.   |   | 2. Date of Death<br>Month<br>DEC •          | Day Year 24, 2005   | 3. Time of Death                             |
| 2                          | Exami  | ner            | 4a. Facility Name (If not institution, give street and number)  BALTIMORE WASHINGTON MEDICAL CENTER  4b. Ci  | ly, Town, or Location of Death<br>LEN BURNIE                            |   | 4c. County of Death<br>ANNE ARUN                              | DEL .  |
| 822                        | Funeral<br>Director  |                | 219 15 3115 1 <sup>M</sup> 2 F 25 Yrs. Month   | der 1 Year If Under 24 Hrs.<br>s Days Hours Min.                        | 8. Date of Birth<br>(Month, Day,<br>Oct. 30 | Year) 9. Birtho<br>Cour<br>1980 Mai                           | place (State or Foreign<br>ntry)<br>1 y land |
| <i>\\</i>                  | aryland<br>•how  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   |   | 1   | Od. Inside City Limits                       |
|                            | ith with the Maryla<br>23a or 28a-f ehov   | Director       | Maryland Anne Arundel Baltimore  10e. Street and Number 10f.   | Zip Code  | 10  | Og. Citizen of What Cour                                      | 1 ☐ Yes 2X No                                |
|                            | ath with   |                | 188 West Meadow Road   | 21225   |   | U.S.  | iuy:   |
| 9036                       | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "naturel", or Items 23a or 28a-f show<br>ont. Ira Medical Exandrate.cost be notified at | by Funeral     | 1 Never Married 2 Married 1 Yes 2 No   | edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2 No Specify: | pecify Yes or No-<br>p Rican, etc.)         | 14. Race - Americ<br>Black, White,<br>Specify: Whi            | etc.   |
| 15-0                       | in 72 h<br>n "natu<br>fedical  | Completed      | 15. Decedent's Education 16a. Decedent's Ut<br>(Specify only highest grade completed) (Give kind of the DO NOT   | sual Occupation<br>work done during most of work<br>use retired)        | king 1                                      | 6b. Kind of Business/Inc                                      | dustry                                       |
| 1212                       | e filed with<br>Il Hygiene<br>other that   |                | 9th Roofer   |   | ]   | Roofing Com   | pany   |
| Maryland 21215-0036        | ed la be   | To Be          | 17. Father's Name (First, Middle, Last)  Gary Lee Downey, Sr.  |   | ne (First, Middle, M<br>`icia Wood          |   |  |
|                            | s 1 and 2 should<br>f Health and Mer<br>item 27 le marke<br>other traumatic  |                | 19a. Informant's Name/Relationship (Type, Print)  Gary L. Downey, Sr./Father  19b. Mailing Addre   | ss (Street and Number or Rui<br>Meadow Road                             | ral Route Number,<br>Baltimon               | City or Town, State, Zip<br>re, Maryland                      | Code)<br>d 21225                             |
| Baltimore,                 |  |                | 20a. Method of Disposition  1 Burial 2 NiCremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Nocemetery, crematory of Bayview Crem             | other place)  |   | Oc. Location - City or To                                     |  |
| Balti                      | permit. Page<br>Department of<br>Important: If<br>eny Injury or<br>once.   |                | 21. Signatury of Funeral Service Licensee 22. Name 4001  | and Address of Facility G   | once Fune<br>av Balti                       | eral Service<br>More. Marvl                                   | e, P.A.                                      |
|                            |  |                | 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the meshock, or heart failure. List only one cause on each line.                                |   |   |   | Approximate<br>Interval Between              |
|                            | Pnysician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)  a. Methadone Intoxication  Due to (or as a consequence of):   |   |   |   | Onset and Death                              |
|                            | Examiner   | -              | Sequentially list conditions, frank, leading to immediate b.   |   |   |   |  |
|                            | acuted<br>nd<br>transit  | Examiner       | cause. Enter Undertying Cause (Disease or injury that initiated events   |   |   |   |  |
| 68760,                     | ficate be executed<br>physicien and<br>s the burial-transit  | edical Ex      | resulting in death) Last  Due to (or as a consequence of):  d  |   |   |   |  |
| P.O. Box 6                 | ettending<br>for use a   | Physician/Med  | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   |   | 11.   | 23d. Date of deliver<br>Month                                 | y<br>Day Year                                |
| ds, P                      | w requires thet the de<br>been signed by the<br>should be detached   | þ              | Part II. D <b>ther significant conditions</b> contributing to death but not resulting in the underlying  | cause given in Part I.  |   | acco use contribute to the                                    | e cause of death?                            |
| Division of Vital Records, | The law requite has been age 2 should  | Completed      |  |   | 24a. Was an autopsy performe                | 24b. Were autop<br>prior to com<br>death?                     | sy findings available                        |
| Vital                      | ysician: The<br>is certificate hi<br>director, page  | Be             | 25. Was case referred to medical examiner?   |   | Check only one)                             |   | 2□ No  |
| Jo L                       | g Physie this neral dir  | n: To          | 1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 □ D  27. Manner of Death 28a. Date of Injury 28b. Time of Find   |   | me 5 Residence<br>28d. Describe how         | ce 6 Other (Specify)  |  |
| isior                      | utending<br>death.<br>ctor: After<br>y the funer   | catio          | 2 Accident investigation 12/24/2005 5:00 A M   | 1 ☐ Yes 2. No   |   |   |  |
| Div                        | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral                                    | Certification: | 4 Homicide determined building, etc. (Specify)  Found Private dwelling   |   | Pasadena Ai                                 | et and Number of Rural<br>State) 1833 Chesa<br>nne Arundel Co | untv MD                                      |
|                            | the Hosp<br>in 24 hou<br>the Fund<br>poletely fi   | Medicai        | 29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurrer control to the basis of examination and/or investigation and manner stated. | at the time, date and place, and in my opinion, death occurr            | and due to the caused at the time, date     | se(s) and manner as sta<br>e and place, and due to t          | ted.<br>the cause(s)                         |
|                            | To To  | 2              | 29b. Signature and title of certifier  Mayure The Gull im  | O.C.M.E   |   | DEC. 25, 200  |  |
| 0                          |  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MAWAR PENN STREI   | ET, BALTIMORE.  | MARYLAND                                    | 21201   |  |
|                            | Sta:<br>Registra   |                | 31. Date filed (Month, Day, Year) 32. Degistrar's Signature DEC 2 9 2005   |   |   | ****  |  |

State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 657 PM BARBARA DECEMBER 15 2005 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Deat **Examiner** BALTIMORE THE JOHNS HOPKINS HOBPITAL NA If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) D7 · 22 · 1927 Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 K F 216.22.335 18 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at JESSUP 1 ☐ Yes 2 No MD HOWARD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 23a c GUILFORD 20794 ROAD 10061 KBU Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or iteme 11. Marital Status 1 ☐ Yes 2 KLNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RETAIL CREDIT MANIAGER 12 TH GRADE YRS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK Be HENRY MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL EXUM (HUSBAND) JESSUP 1006 GUILFORD RD. MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MEADOWRIDGE 4 ☐ Donation 5 ☐ Other (Specify) 12.22.05 ELKRIDGE MO 21. Signature of Funeral Service License VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. MD 21229 23a. Part1. Entertible disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOYIC BRAIN INSMRY SEVEN DAYS /Medical Due to (or as a consequence of) Examiner VENTRICULAR FIBRILLATION were proper stany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien and for use as the burial-transit MYOCANDIAL INFARCTION SEVEN DIS Due to (or as a consequence of): Box 68760. Physician/Medical CORONAMY ARTERY DISEASE FIVE YEARS The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? hes 1□Yes 2X No 2 X No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After To the Hospital or Attending 5 Pending investigation 1 Natural Injury death. 1 Tyes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 DECEMBER 15,2005 SCHENY, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CHENG JOHNS HOPKINS HOSPITAL SUSAN 600 N. WOLFE ST. BALTIMORE MD 21287 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 9:30 BEULAH C. EPPS 12.16.2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days Hours | Min. | 02.11.192 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 1 F 519. Pls. 060 83 Yrs. NC Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other then "neturel", or iteme 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director BALTIMORE GWYNN OAK MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 WALDEN WILLOW USA CT. 21207 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 2 No Specify: ģ Specify: BLACK 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) FOOD SERVICE 12 TH GRADE COOK NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANK COWARD ဥ EVA DIXON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO. MO ANGELUS DURHAM Health Hem 27 DAUGHTER 15 WALDEN WILLOW CT. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: if its any injury or of once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12 30 05 BADO. MO MT. ZION 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Fuperal Service Licensee 22. Name and Address of Facility PUNERAL SERVICE laughn 5151 BAUD. NATU PIKE, BAUD. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lines. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stugo antinon **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physicien and Due to (or as a consequence of): ettending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to de th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed After this certificate hes been s funerel director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2√ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatrent 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပို 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 ☐ Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \( \text{Homicide} \) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed Box 68760. P.0. Records. of Vital or Attending Physician: Division

filed within 72 hours after

Baltimore, Maryland 21215-0036

To the Hospital or Attendin within 24 hours effer death.

To the Funerel Director: Aft completely filled in by the fun Medical 29b. Signature and title of certifier VUD

29c. License number 29d. Date signed (Month, Day, Year)

1838 Greens

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tree Rel 21208

cu

31. Date filed (Month, Day, Year) 2 9

Temur 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

|  |                   | For<br>State<br>Registrar   | State o                                | f Maryla                                       |   | artmer                               |   |                             | and M                  | lental Hy                                       | giene<br>Reg. No.       | 05                            | 42059  |
|--|-------------------|---|--|--|---|--------------------------------------|---|-----------------------------|------------------------|---|-------------------------|-------------------------------|--|
| Dhysinis   |                   | 1. Decedent's Name (First, Middle,  |  |  |   |                                      |   |                             |                        | 2. Date of Dea                                  | ath<br>Day              | Yea                           | 3. Time of Death                                     |
| Physicia<br>/Medic   |                   | Patricia Lee Fr   |  |  |   |                                      |   |                             |                        | Decemb  | er 2                    | 4, 200                        | 5 2:24 A M   |
| Examine  | er                | 4a. Facility Name (If not institution,  | •                                      | mber)  |   | 4b. City<br>Tow                      |   | Location of                 | of Death               |   |                         | County of De $1 {	t timor}$   |  |
| <b>-</b>   |                   | Gilchrist Hospi  5. Social Security Number  | Ce<br>S. Sex                           | 7. Age (In vi                                  | rs. last birthday   |                                      | r 1 Year                                | Il Under:                   | 24 Hrs.                | 8 Date of Birt                                  |                         |                               |  |
| Funeral Director   |                   | 213-36-9778   | 1 □ M 2/□XF                            | 65   |   |                                      | Days                                    | Hours                       | Min.                   | 8. Date of Birt<br>(Month, Day<br>07/13/        | ÿ, Year)<br>1ОД∩        | Ma                            | irthplace (State or Foreign<br>Country)<br>ryland    |
| Α.   |                   | Usual Residence of Decedent   |  |  |   |                                      |   |                             |                        | 0,710,  |                         |                               |  |
| anyla  | 'n                | MD Howard   |  |  | City, Town or L<br>ighland  | ocation                              |   |                             |                        |   |                         |                               | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No               |
| the M  | ecto              | 10e. Street and Number  |  | 11.  | rgiitand  | 104.7                                | p Code                                  |                             |                        |   | 10a Citi                | zen of What (                 |  |
| 3a or  | <u> </u>          | 6655 Luster Dri   | ve                                     |  |   | 207                                  |   |                             |                        |   | USA                     | Len or What C                 | Southly ?  |
| death  | Funeral Director  | 11. Marital Slatus  | 12. Was Dec                            | edent Ever in                                  | U.S. 13.  | Was Dece                             | dent of H                               | spanic Orig                 | gin? (Spe              | ecify Yes or No-<br>Rican, etc.)                |                         |                               | nerican Indian,                                      |
| or Its   | Fu                | 1 Never Married XX Marrie   |  | XXINo  |   | 1 Yes                                |   | Specify:                    | , rueito               | nican, etc.)                                    |                         | Black, Wh                     |  |
| 2-UUSO 72 hours af natural; or   | d by              | 3 ☐ Widowed 4 ☐ Divorced  |  | ates:  | 100 David   |                                      |   |                             |                        |   |                         | Specify: W                    |  |
| in 72<br>in 72<br>feed c   | Completed         | (Specify only highest   | grade completed)                       |  | (Give   | dent's Usu<br>kind of wi<br>DO NOT L | iai Occupi<br>ork done d<br>ise retired | ation<br>during most<br>')  | of worki               | in <i>g</i>                                     | 16b. Ki                 | nd of Busines                 | s/Industry   |
| d within giene.  | E O               | Elementary/Secondary (0-12)   | College (                              | 1-40r 5+)<br>-                                 | Accou   | ntant                                |   |                             |                        |   | Stat                    | e of M                        | aryland  |
| al Hyg   | Bec               | 17. Father's Name (First, Middle, L.  | ast)                                   |  |   |                                      |   |                             |                        | (First, Middle,                                 |                         |                               |  |
| yiand ould be file Mental Hy arked oth   | ဦ                 | Samuel Fine   |  |  |   |                                      |   |                             |                        | e Boyd  |                         |                               |  |
| Mar<br>12 sh<br>h and<br>7 is m<br>traum   |                   | 19a. Informant's Name/Relationshi<br>Kelly Frazer (h  | <sub>р (Турв, Print)</sub><br>usband)  |  |   |                                      | _                                       |                             |                        | al Route Numbe                                  |                         |                               | Zip Code)  |
| Healt<br>Healt<br>Healt<br>Healt<br>Healt  |                   | 20a. Method of Disposition  | usbana /                               | 206  | . Place of Disp   | Lust<br>osition (Na                  | me of                                   | - 1                         |                        | ighland   |                         |                               | or Town, State                                       |
| DETRIMOTE, INTERVIENT C L L 13-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar must be notified at once.  |                   | 1 ☐ Burial XXCremation 3<br>4 ☐ Donation 5 ☐ Other (Spe   |  | State M  | <sub>сететегу, сіге</sub><br>etro Cr  | -                                    |   | 0                           | 1/02                   | /2006   |                         | onsvi1                        |  |
| mit. F<br>portar<br>/ injur  |                   | 21. Signature of Funeral Service Li   |  |  |   |                                      |   | s of Facility               | y Wi                   | tzke Fu   |                         |                               |  |
| Depariment on in in poor   |                   | Myn   |  |  | 5   | 555 T                                | win 1                                   | Knoll                       |                        |   |                         |                               | MD 21045   |
|  |                   | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List o                                      | omplications that only one cause on e  | aused the de                                   | eath. Do not en   | ter the mo                           | de of dyin                              | g, such as                  | cardiac c              | or respiratory ar                               | rest,                   |                               | Approximate<br>Interval Between                      |
| Physician  |                   | Immediate Cause (Final disease or condition   | -a B                                   | vast   | - (a  | nce                                  | _                                       |                             |                        |   |                         |                               | Onset and Death                                      |
| /Medical<br>Examiner   |                   | resulting in death)   | Due to                                 | (or as a cons                                  |   |                                      |   |                             |                        |   |                         |                               | 1 3  |
| to the state of  | e                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to                              | (or as a cons                                  | equence ol):  |                                      |   |                             |                        |   | -                       |                               |  |
| sate be executed hysicien and the burial-transit   | Examiner          | cause. Enter Underlying Cause (Disease or injury that initiated events                                      | C.                                     |  |   |                                      |   |                             |                        |   |                         |                               |  |
| e exe  | EX                | resulting in death) Last  | Due to                                 | (or as a cons                                  | equence ol):  |                                      |   |                             |                        |   |                         |                               |  |
| cate be ex<br>cate be ex<br>cate be ex   | Physician/Medicai |   | d                                      |  |   |                                      |   |                             |                        |   |                         |                               |  |
| wrequires that the death certifical been signed by the ettending phe should be detached for use as t   | /Me               | IF FEMALE:  | 23c. Il yes, ou                        | tcome of pred                                  | nancy   |                                      |   |                             |                        |   |                         | ad Data al d                  |  |
| Beath<br>leath<br>etten  | cian              | 23b. Was decedent pregnant in the past 12 months?   | 1 Live t                               | ointh 2 □ Fe                                   | etal death 3  | ☐Ectopic p                           |   |                             |                        |   | 2                       | 3d. Date of d<br>Month        | Day Year   |
| by the achec   | hysi              | 1 Yes 2 No<br>9 Unknown   | 9□Unkn                                 | own  |   |                                      |   |                             |                        |   |                         |                               |  |
| Sy That are that are that are that are that are deltared are that are the that are the that are the that are that are that are that are th | by P              | Part II. Other significant condition  | s contributing to d                    | eath but not r                                 | esulting in the u   | underlying                           | cause give                              | en in Part I.               |                        | 23e. Did to                                     | bacco u                 | se contribute                 | to the cause of death?                               |
| w requires been signed should be   |                   |   |  | -  |   |                                      |   |                             |                        | 1 🗆 Y   | es 20                   | ZNo 3□F                       | Probably 4 Unknown                                   |
| e taw<br>has b   | Completed         |   |  |  |   |                                      |   |                             |                        | 24a. Was a<br>autop                             | SV                      | prior to                      | aulopsy findings available<br>completion of cause of |
| ding Physician: The I h. After this certificate ha funeral director, page  |                   |   | 1                                      |  |   |                                      |   |                             |                        | 1 Yes   | med?<br>21X No          | death?<br>1 ☐ Ye              | s 2 No   |
| vican:<br>sician:<br>s certifica<br>lirector, p  | o Be              | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No   | Hospital:                              | Inpatient 2                                    | <br>☐ ER/Outpatie   | nt 3 D                               | Othe                                    | No.                         |                        | n <i>(Check</i> on <i>ly oi</i><br>me 5 ☐ Resid |                         | 100                           | 11/10/20   |
| g Phy G  | ⊢ ∤               | 27. Magner of Death   |  | of Injury<br>th, Day Year)                     |   |                                      | 28c. Injury<br>Work                     |                             |                        | 28d. Describe h                                 |                         |                               | ecity) has pice                                      |
| ath.   | atio              | 1)S/Natural 5 Pending<br>2 Accident investiga   | tion                                   | (II, Day real)                                 | Injury  | М                                    |   | res 2 🗆 N                   | VO.                    |   |                         |                               |  |
| r Attenctor: irector:  | Certification:    | 3 Suicide 6 Could no<br>4 Homicide determin   | ad 286. Place                          | of Injury - At                                 | home, farm, st  | reet, factor                         | y, office                               |                             | 1                      | 28f. Location (S<br>City or Tow                 | itreet and<br>m, State) | Number or F                   | Rural Route Number,                                  |
| pital of urs of aral Dilled in   |                   | 00.0.4%   |  |  |   |                                      |   |                             |                        |   |                         | <del></del>                   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and compietely filled in by the funeral director, page 2 should be detached for use as the burial-transit   | edicai            | 29a. Certifier Certifying (Check only 2 Medical E:  | Physician: To the<br>xaminer: On the b | ) best of my k<br>asis of exami<br>ner stated. | nowledge, deal<br>nation and/or in  | th occurred<br>ovestigation          | l at the time<br>n, in my op            | e, date and<br>sinion, deat | d place, a<br>h occurr | and due to the c<br>ed at the lime, c           | ause(s)<br>date and     | and manner a<br>place, and du | as stated.<br>ne to the cause(s)                     |
| To the<br>within<br>To the   | Me                | 29b. Signalure and title of certifier   | 0                                      |  |   |                                      | c. License                              |                             |                        |   |                         |                               | nth, Day, Year)                                      |
|  |                   | > Ulla  | lim                                    |  |   | 9                                    | D 58                                    | 3303                        |                        |   | Vec                     | comber                        | 24 2005  |
| 16   |                   | 30. Name and address of person w  | ho completed caus                      | se ol death (It                                | em 23a) (Type,  | Print)                               | - "                                     | 2.11                        |                        | no n  | .0                      | 21201                         | ,  |
|  |                   | 70 7 01 0   |  | legistrar's S&                                 | Malure A-0-   | 7 7                                  | 1                                       | Dan!                        | m                      | no n  | <b>V</b> )              |                               |  |
| Stat<br>Registra   |                   | 31. Date liled Ments Day, Gear)   | Ub Alex                                | legistrar's Sig                                | A DESCRIPTION OF THE PROPERTY |                                      |   |                             |                        |   |                         |                               |  |

|                                |   |                | 1 - For<br>State<br>Registrar  | State of Ma   | aryland /                             |            | artment<br><i>rtificate</i> |                                       |              |              |                                  | jiene<br>leg. No. | 05               | act figure          | 206                         | 50                   |
|--------------------------------|---|----------------|--|---|---------------------------------------|------------|-----------------------------|---------------------------------------|--------------|--------------|----------------------------------|-------------------|------------------|---------------------|-----------------------------|----------------------|
|                                | Physici   | an             | 1. Decedent's Name (First, Middle, Last  |   |                                       |            |                             |                                       |              |              | 2. Date of Dea<br>Month          | Day               | Y                | ear                 | 3. Time o                   | of Death             |
|                                | /Medic  | cal            |  | riis  |                                       |            |                             |                                       | 1            |              | ecembe                           |                   |                  | 005                 | 3:35                        | A. M                 |
|                                | Examin  | er             | 4a. Facility Name (If not institution, give Vantage House  | street and number)  |                                       |            |                             | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Location o   | of Death     |                                  | 4c.               | County of<br>HOV | Death<br>vard       |                             |                      |
|                                | Funeral   |                | 5. Social Security Number 6. Se  |   | e (In yrs. last l                     | birthday)  | If Under                    | 1 Year                                | If Under     |              | B. Date of Birth                 | 1                 | 9                | . Birthol           | ace (State                  | or Foreign           |
|                                | Director  |                | 579-62-7119 <sup>1E</sup>  | ] M 2 <b>X</b> (X)F   | 93                                    | Yrs.       | Months                      | Days                                  | Hours        | Min. C       | 7709 PI                          | 912               | Wa               | ater                | town,                       | WI                   |
|                                | and w   |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, To                         | wo or Lo   | cation                      |                                       |              |              |                                  |                   |                  | 10                  | d. Inside C                 | its Limita           |
|                                | Manyli<br>1 sho   | ō              | MD Howard  |   | Co1uml                                |            |                             |                                       |              |              |                                  |                   |                  | 1"                  |                             | 2XXV0                |
|                                | r 28a   | Director       | 10e. Street and Number   |   |                                       |            | 10f. Zip                    | Code                                  |              |              | 1                                | log. Citiz        | zen of Wha       | at Count            | ry?                         |                      |
|                                | th with   |                | 5400 Vantage Point   | Road  |                                       |            | 2104                        | 44                                    |              |              |                                  | USA               |                  |                     |                             |                      |
|                                | ems   | Funerai        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?                             | Ever in U.S.                          | 13.        | Was Decede                  | ent of Hi                             | spanic Orig  | gin? (Spec   | ify Yes or No-                   |                   | 14. Race -       | America<br>White, e |                             |                      |
| 36                             | s afte  | by Fu          | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 ∐ Yes 2 <b>X∭</b><br>If Yes, Give<br>Year or Dates:           | lo                                    |            | 1□Yes 2                     |                                       | Specify:     |              |                                  |                   | Specify:         | Whi                 |                             |                      |
| 9                              | be filed within 72 hours after death with the Maryland and Hygiene. And Hygiene death of then "natural", or items 23a or 28a-f show event, I'the Medical Examinar must be notified at | edt            | 15. Decedent's Edu   | cation  | 16                                    | a. Dece    | dent's Usual                | Occupa                                | tion         |              |                                  | 16b. Kir          | nd of Busir      | ness/Ind            | ustry                       |                      |
| 215                            | within 73<br>ene.<br>then "na   | piet           | (Specify only highest grad   | e completed) College (1-4or 5                                   |                                       | (Give      | kind of worl<br>DO NOT use  | k done d                              | urina most   | t of working |                                  |                   |                  |                     | ,                           |                      |
| 2                              | filed withir<br>Hygiene.<br>other then<br>ant, "is M  | Completed      | 12   | 4   | H                                     | omem       | aker                        |                                       |              |              |                                  |                   | home             |                     |                             |                      |
| gue                            | d be fil<br>antal H<br>ted oth  | Be             | 17. Father's Name (First, Middle, Last) Louis Schmiedeman  |   |                                       |            |                             |                                       |              |              | First, Middle, .<br>abhegge      |                   | Sumame)          |                     |                             |                      |
| Ž                              | ges 1 and 2 should be<br>it of Health and Mental<br>If item 27 is marked<br>or other treumatic ev   | 2              | 19a. Informant's Name/Relationship (T)   | rne Print)  | 10                                    | 9h Mailir  | Address                     |                                       |              |              | Route Number                     |                   | Town Str         | to Zin i            | Codol                       |                      |
| S                              | and 2 salth ar n 27 ls  |                | Helen Barker (ne:  | , . ,   |                                       |            |                             |                                       |              |              | Yreka                            |                   |                  |                     | 3000)                       |                      |
| J.                             | as 1 a<br>of Hea<br>item  |                | 20a. Method of Disposition   |   | 20b, Place                            | of Dispo   |                             | e of                                  | 1            | Da           | te                               |                   | cation - Cit     |                     | vn, State                   |                      |
| Ë                              | ry it   |                | 1 ☐ Burial XX Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)                                | temoval from State  | Metro                                 | -          | •                           |                                       | 0            | 1/02/        | 2006                             | Cato              | nsvil            | 1e,                 | MD                          |                      |
| Baltimore, Maryland 21215-0036 | permit. Departm Importe any inju  |                | 21. Signatury Funeral Service Licens   | Lemming   | <b>a</b>                              | 42         | Name and                    |                                       |              | WIL:         | zke Fur<br>ad (                  | nera<br>Colu      | 1 Hom            | es,<br>MD           | Inc.<br>2104                | 5                    |
|                                |   |                | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or                 | ications that caused<br>ne cause on each lin                    | the death. Do                         | o not ent  | er the mode                 | of dying                              | , such as    | cardiac or   | respiratory arr                  | est,              |                  |                     | Approximat<br>Interval Bel  | tween                |
|                                | Pnysician   |                | Immediate Cause (Final disease or condition resulting in death)                                  | a. END  | Stage                                 | C          | may                         | tre                                   | He           | int          | Moture                           | +                 |                  |                     | Onset and<br>Mercy          |                      |
|                                | /Medical<br>Examiner  |                | resulting in dealiny   | Due to (or as a   |                                       | e of):     | 0                           |                                       |              |              | 0                                |                   |                  |                     | a.                          |                      |
|                                |   | er             | Sequentially list conditions, if any, leading to immediate                                       | Due to (or as a   |                                       | e of).     | 0.                          |                                       |              |              |                                  |                   |                  |                     |                             | 4                    |
|                                | cuted   | Examiner       | any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | tryour  | temi                                  |            | em                          | + 0                                   | Ducon        | roes!        |                                  |                   |                  |                     | ys                          |                      |
| ,00                            | e exe<br>sian ar<br>urial-t   | i Ex           | resulting in death) Last   | Due to or as a  | consequence                           | e of):     |                             |                                       |              |              |                                  |                   |                  |                     |                             |                      |
| 8760,                          | death certificate be executed<br>e attending physician and<br>id for use as the burial-transit  | dicai          |  | d   | _                                     |            |                             |                                       |              |              |                                  |                   |                  | -                   |                             |                      |
| Box 6                          | attending p   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant   | 3c. If yes, outcome   |                                       |            |                             |                                       |              |              |                                  |                   | 3d. Date o       | f deliver           | ,                           |                      |
| ĕ.                             | death<br>d for t  | iciar          | in the past 12 months?   | 1□Live birth<br>4□Pregnant at                                   |                                       |            | Ectopic pre<br>Other (spe   | gnancy<br>cify)                       |              | -            |                                  |                   | Month            |                     |                             | Year                 |
| P.0.                           | the<br>y th<br>iche   | hys            | 9 Unknown  | 9□ Unknown  |                                       |            |                             |                                       |              |              |                                  |                   |                  |                     |                             |                      |
| Records, I                     | w requires that<br>been signed b<br>should be deta  | by             | Part II. Dther significant conditions con  | ntributing to death bu  | it not resulting                      | in the ur  | nderlying ca                | use give                              | n in Part I. |              | 23e. Did tot                     | oacco us<br>es 2  |                  | te to the           |                             | death?<br>Unknown    |
| ecc                            | aw<br>is b  | Completed      |  |   |                                       |            |                             |                                       |              |              | 24a. Was a autops                | V                 | prio             | r to com            | sy findings<br>pletion of c | available<br>ause of |
| _                              | Page 1  |                |  |   |                                       |            |                             |                                       |              |              | perform<br>1 Yes 2               | ned/<br>2. No     | dea              |                     | !□ No                       |                      |
| Vital                          |   | o Be           | 25. Was case referred to medical examiner?   | lospital:<br>1 ☐ Inpatier                                       | • • • • • • • • • • • • • • • • • • • |            | 4 T BO                      | Othe                                  |              |              | Check on on                      |                   |                  |                     |                             |                      |
|                                |   | $\vdash$       | 27. Manner of Death  | 28a. Date of Injur<br>(Month, Day                               |                                       | . Time of  |                             | c. Injury                             | at           | -            | 5 Reside                         |                   |                  | Specity)            |                             | _                    |
| ion                            |   | atio           | 1   Natural 5 □ Pending 2 □ Accident investigation   | (Montin, Day  | rear)                                 | Injury     | М                           | Work¹<br>1 □ Y                        | es 2□N       | No           |                                  |                   |                  |                     |                             |                      |
| Division                       | of or Attend<br>after death<br>Director: /  | Certification; | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Inju<br>building, etc                             | ry - At home,<br>(Specify)            | farm, stre | et, factory,                | office                                |              | 28           | f. Location (St.<br>City or Town |                   | Number o         | r Rural             | Route Num                   | ber,                 |
|                                | Hospitel (4 hours a Funerel C   |                | 29a. Certifier 18 Certifying Phys  | Pician: To the heet o   | f my knowled                          | ao dooth   | nonumed o                   | t the time                            |              | d eleas as   | d due to the e                   |                   |                  |                     |                             |                      |
|                                | To the Hospitel or Attenwithin 24 hours after deati<br>To the Funerel Director:<br>completely filled in by the  | edical         | (Check only 2 Medical Exami  | sician: To the best oner: On the basis of<br>and manner states. | examination a                         | and/or inv | estigation, i               | n my op                               | inion, deatl | h occurred   | at the time, da                  | ate and           | place, and       | due to t            | he cause(s                  | i)                   |
|                                | To the Hospitel within 24 hours a To the Funeral c completely filled  | Me             | 29b. Signature and title of certifie   | 4   |                                       |            | 29c.                        | License                               | number       |              | 2                                | 9d. Date          | signed (A        | fonth, D            | ay. Year)                   |                      |
| )                              | X   |                | 160 Mge  | inns  |                                       |            | ۵                           | - (                                   | 348          | 68           |                                  | 12                | 77               | -0                  | 15                          |                      |
|                                | 10  |                | 30. Name and address of person who co  | and manner star   | eath (Item 23a                        | Sut        | Print)                      | Pari                                  | lanz         | C            | dechia                           | +,                | uw               | 2                   | :644                        |                      |
|                                | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 2 9 2001   | 32. Registra  | r's Signature                         | Ace        | Ser.                        |                                       | U            |              |                                  |                   |                  |                     |                             |                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedept's Name (First, Middle, Last, Month Year Physician DECEMBER 28, 2005 E:59A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Saint Joseph Medical Center If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign 6. Sex 1 M 2 ☐ F Social Security Number **Funeral** Hours Months Days 01-992 MARYLAND 219 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County orient: If Item 27 is marked other then "naturel", or Items 23a or 28a-1 show injury or other treumstic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 No BALT MORE MD Director DMOR 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 2123 280 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: if if item 27 ie marked other then "naturel" on the freumetic even. 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status med Forces?

Yes 2 No
Yes, Give 2 Married 1 Never Married 1 TYes 1 Yes 2 No Specify Specify: Whit If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rulal Rout, Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 280 19 Itel MOKE aai Ob. Place of Disposition cemetery, cremato (Name of or other Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1431/05 BALTIMORE, MD 21234. 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility 8800 HARFORDED noth EVANS FUNERAL CHAPET 23a. Part . Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown SMALL BOWEL OBSTRUCTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an RENAL FAILURE autopsy 1 🗌 Yes 1 🗌 Yes this certificate 20 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 1 Natural
2 Accident Injury 5 Pendina 1 Yes 2 🗌 No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation in my opinion, death occurred at the time. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifie 29c. License number 28 05 21 D 37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON MARYLAND 21204 76 71 05 ER 32. Registrar's Signature IM 14.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month Day Year)

9 2005

|   |                  | Amend item#9,per  | <b>HH, C851, 1</b><br>State of N                      | 9/06 11<br>laryland / Depa   | artment of I                               | Health and                               | Mental Hy                              | giene                                    | ie.  |
|---|------------------|---|---|--|--|--|--|--|--|
|   |                  | State<br>Registrar  |   | Ce   | rtificate of                               | Death                                    | 1                                      | Reg No 15                                | 62062  |
| Physicia  | an               | 1. Decedent's Name (First, Middle, L<br>Evelyn  | ast)  | Feas   | ster                                       |  | 2. Date of Dea<br>Month                |  | ear 3. Time of Death 11:45p M  |
| /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, gi   | ive street and number                                 | 7)   | 4b. City, Town,                            | or Location of Dea                       |  | 4c. County of                            |  |
|   |                  | Future Care-Ch  | arles Vill  | age  | Balti                                      | more                                     |  | NA                                       |  |
| Funeral<br>Director   |                  | 5. Social Security Number 6. 212–20–3503  |   | ge (In yrs. last birthday)<br>83 Yrs.  |  | If Under 24 Hr                           |  | y, Year)                                 | Birthplace (State or Foreign<br>Country)                               |
| and   |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town or Lo  | ocation                                    |  |  |  | 10d. Inside City Limits  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic avant, the Medical Examinational by notified at once. | ō                | Md.   | NA  | Balt   | imore                                      |  |  |  | 1 Yes 2 □ No   |
| the 1   | Director         | 10e. Street and Number  |   | 2010   | 10f. Zip Code                              |  |  | 10g. Citizen of Wh                       |  |
| 3a or   |                  | 6003 m/s 1 m  |   |  |  | 10                                       |  |  |  |
| ms 2  | Funeral          | 2621 Kirk Aven  | 12. Was Deceden                                       |  | Was Decedent of                            | Hispanic Origin? (                       | Specify Yes or No                      | - 14. Race -                             | American Indian,   |
| or Ita  | 五                | 1 ☐ Never Married 2 ☐ Married   | Armed Forces  | (No  | If Yes, specify Cut                        |  | rto Rican, etc.)                       |  | White, etc.  |
| Egi.  | þ                | 3 Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates                         | :  | 1□Yes 2∏ No                                | Specify:                                 |  | Specify:                                 | Black  |
| natu  | Completed        | 15. Decedent's t  |   | 16a. Dece  | dent's Usual Occu<br>kind of work done     | pation<br>during most of we              | orkina                                 | 16b. Kind of Busin                       | ness/Industry  |
| an an   | du               | Elementary/Secondary (0-12)   | College (1-4o   | 1ife.  | DO NOT use retire                          | ed)                                      | 9                                      |  |  |
| har th  |                  | 12th grade  | -11   | Tie  | cket Cle                                   |  |  | Dunbar N                                 |  |
| avar  | Be               | 17. Father's Name (First, Middle, Las   | st)   | ra: 3 3 2  |  |  |  | Maiden Sumame)                           |  |
| Merke   | ဥ                | James   |   | Williams   |  | Laur                                     |  | O'Nea                                    |  |
| la m  |                  | 19a. Informant's Name/Relationship  |   |  |  |  |  | er, City or Town, St                     |  |
| of Health ar  | ij.              | Ella Lucretia Fe  | easter Da   | The state of the s |  | Avenue, h                                | Baltimore                              |  | 1218   |
| if ite  |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation 3   | ☐Removal from Stat                                    | 20b. Place of Dispo<br>cemetery, cre   | matory or other pla                        | · 1                                      | Date                                   | 20c. Location - Ci                       | ty or Town, State  |
| tant:   | 1                | 4 Donation 5 □ Other (Spec  | city)   |  | ill Cemet                                  | tery! 1                                  | -3-06                                  | Anne Ari                                 | undel Co., Mo  |
| Depar<br>Impor<br>any in  |                  | 21. Algnature of Funeral Service Lie  | . Walter  | -/   | 2. Name and Addr<br>March F.H              | ,  |  | nore, Morth A                            | d.   |
| nysician  |                  | 23a. Part 1. Enter the disease, or consock, or heart failure. List only Immediate Cause (Final disease or condition               | 48  | ed the death. Do not en<br>line.   |  |  | ac or respiratory ar                   | rest,                                    | Approximate<br>Interval Between<br>Onset and Death                     |
| /Medical<br>xaminer   |                  | resulting in death)   |   | s a consequence of):   | 3  |  |  |  | US KNOWS   |
| kaminer   |                  | Sequentially list conditions  | o Perc  | LIZZE  | 5  |  |  |  | LINKNIE  |
| ==  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or a  | s a consequence of):   |  |  |  |  |  |
| and<br>-tran:   | cam              | that initiated events resulting in death) Last  | c. HTY  | <u> </u>   |  |  |  |  | UNKows   |
| nysician and<br>he buriat-transit   |                  |   | Due to (or a  | s a consequence of):   |  |  |  |  |  |
| physi<br>the t  | dical            |   | d   |  |  |  |  |  |  |
| ding j  | /Me              | IF FEMALE:  | 23c. If yes, outcom                                   | e of pregnancy   |  |  |  |  |  |
| ed by the attending phy<br>detached for use as th   | by Physician/Med | 23b. Was decedent preor ant in the past 12 months?  1 Tyes 2 MNo 9 Tunknown   | 1 Live birth  | 2 Fetal death 3  | Dectopic pregnand<br>Other (specify)       | Э  |  | 23d. Date of Month                       | ,  |
| d by<br>Jetac   | Ph               | Part II. Dther significant conditions   | contributing to death                                 | but not seculting in the u   | andarking aguas a                          | von in Bort I                            | 230 Did to                             | phagon use contribu                      | ute to the cause of death?   |
| 50  |                  |   | ooming to down  | Dat Hot Possiting #1 (110 to   | indonying dadad gi                         | voi iii aiti.                            | 1 🗆 Y                                  |  | Probably 4 Unknow  |
| been sig  | etec             |   |   |  |  |  | -                                      |  |  |
| nis certificate has t<br>I director, page 2 s   | Completed        |   |   |  |  |  | 24a. Was<br>autop<br>perfor<br>1 ☐ Yes | prior dea                                | re autopsy findings available to completion of cause of ath?  Yes 2 No |
| rtifica<br>tor. p   | Be C             | 25. Was case referred to medical  |   |  |  | 26. Place of Je                          | ath (Check only o                      |  | ,100 2010  |
| this ce<br>al direc   | ToE              | examiner?   | Hospital: 1 Inpa                                      | tient 2 ER/Outpatie  | nt 3 DOA                                   | hor .                                    |  | dence 6 Other                            | (Specify)  |
| <b>⇒</b> ∞  | :u               | 27. Manner of Death   | 28a. Date of In<br>(Month, D                          | jury 28b. Time o   | f 28c. Inju                                |  | 7                                      | now injury occurred                      |  |
| ector: After<br>by the funer  | atio             | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigati   |   | ay / out/  |  | Yes 2 No                                 |  |  |  |
| . S .⊆  | Certification:   | 3 Suicide 6 Could not determine   | d 289. Place of I                                     | njury - At home, farm, str<br>etc. (Specify)   | reet, factory, office                      |  | 28f. Location (S<br>City or Tow        | Street and Number<br>vn, State)          | or Rural Route Number,   |
| within 24 hours and<br>To the Funeral Dir<br>completely filled in   | edical (         | 29a. Certifier Certifying F (Check only one)  | Physician: To the beseminer: On the basis and manner: | t of my knowledge, deat<br>of examination and/or in  | h occurred at the ti<br>vestigation, in my | ime, date and plac<br>opinion, death occ | e, and due to the curred at the time,  | cause(s) and mann<br>date and place, and | er as stated.<br>d due to the cause(s)                                 |
| omple   | Me               | 29b. Signature and title of certifier   |   |  | 29c. Licen                                 | se number                                |  | 29d. Date signed (i                      | Month, Day, Year)  |
| s + 0   |                  | 1   |   | 22   |  |  |  | 12/27                                    | 05.  |
| 7   |                  | 30. Name and address of person who  |   | death (Item 23a) (Type   |  | 059054                                   | -                                      | 1-1-1                                    | -  |
| ,   |                  | 7   | o completed cause of                                  |  | •  | - MT D                                   | 0 0                                    | - R.11                                   | MD 21217   |
| Sta   | te               | 31. Date filed (Month, Day, Year)   |   | trar's Signature   | 2 00 62 1                                  | 1 100                                    | JUNE 14-                               | K IXIA                                   | 1-17 517   |
| ຸ ຣເລ<br>Registr  |                  |   | 2005  |  | South )                                    |  |  |  |  |

DHMH 17 Rev 1/2001

11:45 pm

December 26, 2005

Feaster, Evelyn W.

| Physici   | ian   | 1. Decedent's Nar  | me (First, Midd  | dle, Last)   | )  | Rort   | ha Falc  | ertificate of  |  | 2. Date of<br>Month  | Da   | y Year   | 3. Time of Death<br>6:38 a   |
|---|---|--|--|--|--|--|--|--|--|--|--|--|--|
| /Media  |   | 4a. Facility Name  | (If not institution  | on aive  | street and n   |  | iia i aici   | 4b. City, Town, o  | or Location of I   | Death  |  | 20, 2005<br>County of Death  |  |
| Examir  | ner   | 4a. r domy riamo   | (ii rot ii ottotic   |  | 4 Cherat   |  | ad   | 45. Oly, Form, C   |  | Baltimore  | 1  |  | <b>V</b> A   |
| uneral  | -   | 5. Social Security   | Number   | 6. Sex   |  |  | (In yrs. last birthd   | y) If Under 1 Year   | ff Under 24  | Hrs. 8. Date of I  | Birth  |  | aplace (State or Foreig  |
| irector   |   | 219-16   | 5-7310   | 1 🗆  | ]M 2 <b>∑</b> F  |  | 91 Yrs   | Months Days  | Hours  |  | Day, Year) 5, 1914   |  | o. Carolina  |
| 10.00   |   | Usual Residence  |  |  |  |  |  |  |  |  |  |  |  |
| show  | _   | 10a. State   | 10b. Count   |  | 10   | - '  | Oc. City, Town or  |  | Baltimore  |  |  |  | 10d. Inside City Limit 1   Yes 2 N   |
| Ba-f  | ecto  | Maryland   |  | N/   | /A   |  |  |  | alumore  |  |  |  |  |
| 0 4   | 급   | 10e. Street and N  | aton Road  | d  |  |  |  | 10f. Zip Code  | 2122   | =  | 10g. Cil   | tizen of What Cou<br>U.S.  | •  |
| "natural", or items 23s or 28s-f show<br>colcal Expoduer coust by notified at                         | Funeral Director  | 11. Marital Status   |  |  | 12. Was Dec  | cedent Evi   | erin II S 1  | 3 Was Decedent of H  |  |  | Mo-  | 14. Race - Amer  |  |
|   | Ξ   | 1 Never Mai  |  |  | Armed F  |  |  | <ol><li>Was Decedent of F<br/>If Yes, specify Cub.</li></ol>   | an, Mexican, F   | uerto Rican, etc.)   | 10   | Black, White   |  |
| 0, 1  | þ   | 3 XWidowed   |  |  | If Yes, G<br>Year or   | ive  |  | 1 ☐ Yes 2 ☐XNo   | Specify:   |  |  | Specify:   | Black  |
|   | Completed   | /500   | 15. Decede   |  |  | 0  | 16a. De  | cedent's Usual Occup   | oation   | f dela a   | 16b. K   | (ind of Business/li  | ndustry  |
|   | pie   | Elementary/Sec   | ondary (0-12)  |  |  | (1-4or 5+)   | lif  | ive kind of work done a. DO NOT use retire   | d)   |  |  | Baltimore C  | ity School   |
| marked other than   | Son   | 12   | 2  |  |  |  |  | School C   | rossing G  | uard   |  | Datamore   | nty Oction   |
| d oth   | Be  | 17. Father's Name  |  |  |  |  |  |  | 18. Mother's   | Name (First, Midd  |  |  |  |
| arke  | ပ္  |  | CI   | laude  | Sledge   |  |  |  |  |  | Mary S   |  |  |
| 0 2   |   | 19a. Informant's h   |  |  |  |  | 19b. M   | ailing Address (Street   |  |  |  |  | p Code)  |
| tem 27<br>other tra   |   | Anna Jol   |  | augnte   | er<br>   |  | 20h Place of Di  | 634 Cheraton   | Road Ban   | Imore, Maryla  | _  |  |  |
| or of   |   | 20a. Method of Di  | Sposition<br>2 Cremation   | 3 □R   | lemoval from   |  | cemetery, o  | rematory or other plac   | ce)  |  |  | ocation - City or T  |  |
| Important: If Item 2<br>any injury or other<br>snce.  |   |  | 5 Other (  |  |  |  | Ark  | utus Memorial  |  | 12/24/05   |  | Baltimore,   | Maryland   |
| any ir  |   | 21. Signature of F   | -uneral Service  | e Liu  | 1  |  | -  | 22. Name and Addre   | ,  | unaral Sanic   | a P A  |  |  |
|   | 1-1   | 220 Parti Fetor  | ey 4   |  | -> Le  | 1  |  | 1300 E   | utaw Plac  | uneral Servic<br>e Baltimore, I  | Vid 212  | 17   | 7  |
|   |   | shock, or he   | an fallura lis   | or compi   | ications mai   |  |  |  |  |  |  |  |  |
| sician  |   | 1  |  | st only or   | ne cause on  | ach line.  |  |  |  | rdiac or respiratory   | arrest,  |  | Approximate<br>Interval Between<br>Onset and Death   |
|   | 3   | fmmediate Cause<br>disease or conditi<br>resulting in death  | (Final   | st only or   | i 0  | ach line.  | Socre  | •  | 1  | lear   | arrest,  |  | Interval Between<br>Onset and Death  |
| edical<br>miner   |   | fmmediate Cause<br>disease or conditi<br>resulting in death  | (Final   | st only or   | 116  | chad<br>(or as a c   |  |  | 1  |  | arrest,  |  | Interval Between<br>Onset and Death  |
| edical  | e.  | disease or conditi<br>resulting in death   | (Final<br>ion<br>)   | st only or   | Due to   | chd<br>(or as a c  | Socre consequence of):   |  | 1  |  | arrest,  |  | Interval Between<br>Onset and Death  |
| dical<br>niner  | niner   | disease or condition resulting in death  Sequentially list condition if any, leading to it cause. Enter Und  | e (Final<br>ion<br>)<br>conditions,<br>immediate<br>derlying   | st only or   | Due to   | chd<br>(or as a c  | Sacre  |  | 1  |  | arrest,  |  | Interval Between<br>Onset and Death  |
| dical<br>niner  | xaminer   | disease or conditi   | e (Final<br>ion<br>)<br>conditions,<br>immediate<br>derlying<br>or injury<br>ts  | st only or   | Due to   | chad<br>o (or as a c<br>o (or as a c   | Socre consequence of):   |  | 1  |  | arrest,  |  | Interval Between<br>Onset and Death  |
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| edical<br>miner   | edicai  | disease or conditresulting in death resulting in death Sequentiafly list of any, leading to icause. Enter Und Cause (Disease of that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1 □ Yes 2   | e (Final ion )  conditions, immediate terlying or injury is ) Last   |  | Due to  Due to  Due to  Due to   | o (or as a co o (or a)))))))))))   | consequence of):  consequence of):  pregnancy Fetal death  |  | Ls u   |  |  | 23d. Date of deliv   | Interval Between Onset and Death  5 Me - Hh s  |
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| dical<br>niner  | Physician/Medicai   | disease or condit resulting in death resulting in death Sequentiafly list of any, leading to i cause. Enter Und Cause (Disease or that initiated even resulting in death)  IF FEMALE: 23b. Was decede in the past 1: 1  Yes 2 9  Unknow  | o (Final ion )  conditions, immediate lerlying // injury is j. Last  ant pregnant 2 most s?  |  | Due to  Due to  Due to  Due to   | o (or as a coordinate of birth 2 (or and a time)   | consequence of):  consequence of):  pregnancy Fetaf death ne of death  | 2 Dack   | Ls u   | lor  |  | Month  | Interval Between Onset and Death 5 Au - Hh s   |
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Garnett Madeline Feldman December 24, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford 111 Glenmore Court If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Nov. 24, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Ohio 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F Yrs. Director 82 294-14-7559 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene and the file and 27 is marked other than "natural", or Items 23a or 28e-f show that it is not 7 is marked other than "natural", or here is not it is not 1 and 1 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Bel Air 1 ☐ Yes 2 No Md. Harford Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21014 Funeral 111 Glenmore Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) communications assignment clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Anne Yutte William H. Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State. Zip Code) 111 Glenmore Court, Bel Air, Md. 21014 Catherine Meadowcroft/daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12/28/05 Baltimore, Md. permit. Page Department of Important: If any injury of once. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. Beean a 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ostive **Physician** Cong disease or condition resulting in death) /Medical Due to ( as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed as the burial-fransit nding physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) signed by the be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' this certificate 1 ☐ Yes I ☐ Yes 2 ☐ No 200 No the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Dung 14's 1 ☐ Yes 2 🕅 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural death. 1 TYes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗍 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) Dacember 30. Name and ddress of person who completed cause of death (Item 23a) Type, Print) Nor Fur KGS Lesons 31. Date filed (Month, Day, Year) 32. Registrar's Signature State liver to food Registrar

|            |   |                | For<br>State<br>Registrar   | State of   | Marylar                      |  | artment of H<br>tificate of L                                     |   | Mental Hyg                                   | iene<br>2005<br>eg. No. | 42066   | ļ     |
|------------|---|----------------|---|--|------------------------------|--|---|---|--|-------------------------|---|-------|
|            | Physicia<br>/Medic  |                | Decedent's Name (First, Middle, I   |  | ce M.                        | Finchan  | 1   |   | 2. Date of Deat<br>Month                     | h<br>Day Ye<br>26 200   |   |       |
|            | Examin  |                | 4a. Facility Name (If not institution, g<br>St. Agnes Hosp:   |  | iber)                        |  | 4b. City, Town, or<br>Baltim                                      |   | th   | 4c. County of I         | Peath<br>/A   |       |
|            | Funeral<br>Director   |                | 217 22 8047   | Sex<br>1 □ M 2 🔀 F   | 7. Age (In yrs.<br>78        | last birthday)<br>Yrs.   | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs<br>Hours Min                      |  | Year) 9.<br>1927 M      | Birthplace (State or Fo<br>Country)<br>laryland             | reign |
|            | Maryland<br>f show  | or             | Usual Residence of Decedent  10a. State 10b. County  Maryland N/A   |  |                              | ty, Town or Lo<br>Baltimo  |   |   | <u> </u>                                     |                         | 10d, Inside City L  |       |
|            | 3a or 28a-  | Direct         | 10e. Street and Number 3310 Benson A  | venue  |                              |  | 10f. Zip Code 212   | <br>27  | 1  | 0g. Citizen of Wha      | t Country?  |       |
| 36         | 72 hours after death with the Maryland<br>natural', or Items 23a or 28a-f show<br>lical Evantrat must be notitied at      | by Funerai     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced   | 12. Was Dece<br>Armed For<br>1 Yes<br>If Yes, Give<br>Year or Da | ces?<br>2 <b>X</b> No<br>e   | ]  | Vas Decedent of Hi<br>I Yes, specify Cubar<br>I ☐ Yes 2X No       | spanic Origin? (S<br>n, Mexican, Puer<br>Specify: | Specify Yes or No-<br>to Rican, etc.)        | Black, V                | American Indian,<br>White, etc.                             |       |
| 21215-0036 | be filed within 72 hours<br>ital Hygiene.<br>d other than "natural", '<br>event, I'm Medical Era                          | Completed      | 15. Decedent's (Specify only highest of Elementary/Secondary (0-12)   | Education  |                              | (Give<br>life. I   | lent's Usual Occupa<br>kind of work done d<br>DO NOT use retired, | uring most of wo                                  | orking                                       | 16b. Kind of Busine     |   |       |
| land 5     |   | To Be Co       | 8th<br>17. Father's Name (First, Middle, La<br>Char   | les Price  | e                            | ract   | ory Super   | 18. Mother's Na                                   | me (First, Middle, M<br>Jeannette            | Maiden Sumame)          | nouse   |       |
| , Maryland | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>othar traumatic   |                | 19a. Informant's Name/Relationship Marjorie Jones   |  |                              | 642 S  | outh Pays   | on Stree  | ural Route Number<br>et Bal                  |                         | re, <i>Zip Code)</i><br>Maryland 21                         | .223  |
| Baltimore, | Page<br>ent o<br>nt: If   |                | 20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Special Control of the Control | cify)  | ומושו                        | dar Hil  | sition (Name of<br>natory or other place<br>1 Cemeter             | y 12/3  | 30/2005 I                                    |                         | , Maryland  |       |
| Ba         | permit. Departm Importa any Inju  |                | 21. Signature of Funeral Service Lic  | amerol   | ishi                         | 4(   | 001 Ritch   | ie Highw  | vay Balt                                     | imore, Ma               | ice, P.A.<br>ryland 212                                     | 25    |
|            | Prrysician<br>/Medical  |                | 23a. Part 1. Enter the disease of co<br>shock, or heart failure. Let on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | y one cause on ea  | ach line.                    | mbol   | er the mode of dying  | , such as cardia                                  | c or respiratory arre                        | est,                    | Approximate Interval Between Conset and Deat                |       |
|            | Examiner  | ıer            | Sequentially list conditions,   | b  | or as a consecutive          | nuence of):  The property of t | fame  | ir  | . (  | A Market Banking        | Iday  |       |
| ,0         | icate be executed<br>physician and<br>s fhe burial-transit  | i Examine      | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | c. Due to (c   | or as a consec               | juence of):  | Fall  |   | 18 HO)                                       | ACOURT EXAM             | day   |       |
| ς 68760,   |   | Medicai        | IF FEMALE:  | d  |                              |  |   |   | The files and                                |                         |   |       |
| P.O. Box   | The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as         | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |  | nth 2□Feta<br>antattime of o | al death 3   | Ectopic pregnancy Other (specify)                                 | CERT  | HCA,   | 23d. Date of<br>Month   | delivery<br>Day Year  |       |
| Records, P | w requires fhat<br>been signed b<br>should be deta  | by             | Part II. Other significant conditions Coronary arter  | zy dese  | sse c                        | grear  | nderlying cause give  | n in Part I.                                      | 23e. Did tob                                 |                         | e to the cause of death                                     |       |
| al Reco    |   | Completed      | Hypertenseon  | Recon<br>- Deal  | t eon                        | nan  | thrombi   |   | 24a. Was an autops perform                   | y prior<br>ned? deat    | autopsy findings avai<br>to completion of cause<br>yes 2 No |       |
| of Vital   | Phyaician: Tribis certificateral director, p  | To Be          | 25. Was case referred to medical examiner? 1 ☑ Yes 2 ☑ No 27. Manner of Death   |  |                              | ER/Outpatien   |   | r. 4 🗌 Nursing I                                  | ath (Check only one                          | nce 6 Other (5          | Specify)  |       |
| Division   | ath.<br>r: After  | Certification: | 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not   | be 28e. Place  | of Injury - At h             | ome, farm, str   | Work  | es 2 No   | 28d. Describe ho Sulf L. 28f. Location (Str. | ct fell                 | r Rural Route Number,                                       |       |
| Ö          | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune | ledical Cert   | 29a. Certifier 1 Certifying   | Physician: To the  | best of my kno               | ospita   | occurred at the tim   | e, date and place                                 |  | tiwove                  | r as stated   | 1     |
| )          | To the P<br>within 24<br>To the F<br>complete   | Medi           | 29b. Signature and title of certifier   | and mann   | er stated.                   | len, le  | <del></del>   | number 969  | ·C 25  | eenely 2                | onth, Day, Year)  |       |
| 3          |   |                | 30. Name and address of person wh<br>WILLIAM J. HICK  | o completed cause  | of death (Iter               | п 23a) (Туре,<br>WES Д   | Print)  | BALT WAR  |  |                         | /   |       |
| ė          | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 2 9 200   | 32. Re   | ogistrar's Signa             | ature  |   |   |  |                         |   |       |

FLORENCE MI.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** DECEMBER 23, 2005 8:20 PM /Medical 4a. Facility Name (If not institution, give street and number) or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL DRE Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊋M 2□F Min 244-56-3103 Yrs. Director 65 N.C Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director GA Screven Sylvania 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 114 Contryside Itams 23g Drive 30467 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ Specify: Black 3.☐ Widowed 4 ☐ Divorced natural 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator

18. Mother's Name (First, Middle, Maiden Sumame) 9th grade Logging 17. Father's Name *(First, Middle, Last)* Arthur Graham Be Is marked of Pages 1 and 2 should be Magnolia George 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Stam 27 Louise Elaine Anderson-Daughter 1963 Savannah Highway Sylvania GA 30467

20a. Method of Disposition

20b. Place of Disposition (Name of cametery, crematory or other place)

20c. Location - City of Cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō = 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö ertment ortant: If njury o George Cemetery Whiteville NC 12-30-05 permit.
Deportra
Importa
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March FH East 1101 East North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner the burial transit Hospital or Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No performe 2 No 25. Was case referred to medical 26. Place of Death Check on one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 21210 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 23, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOIFE STREET, BAIL MORE, MARYLAND 21287 31. Date filed (Month, Day, Year) 2005 Registrar

Amend item#1, perMD G850, 12/29/05 TT State of Maryland / Department of Health and Mental Hygiene 05 For State Registra Certificate of Death Reg. No. Vernetta Bernardine Greenwood 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician 11994M een wood /Medical 4a. Facility Name (If not institution, give street and number) Town or Location of Death 4c. County of Death Examiner 160 Baltimore e 205 MATE If Under 24 Hrs. cial Security Number 7. Age (In yrs. last birthday, Year Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 □ M 2√□ F 212-58-1915 Yrs Director 54 Maryland Mar 23, 1951 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Mudical Examinar must be notified at 1 Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ٠.٥٠ 2444 Nevada Street Items 23a 21230 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours effer death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore. Maryland 21215-0036 1 Yes 2 No Specify: Black 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Admiral Insurance Company Insurance Agent of Health and Mental Hygie I Item 27 Is marked other t r other traumatic sysnt, the 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vernon Hawkins Mildred Hawkins 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2444 Nevada Street Baltimore, Maryland 21230 Chimeira N. Greenwood 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 5 = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State rtment rtant: If njury or 12/27/05 4 ☐ Donation 5 ☐ Other (Specify) Brooklyn Park, Md. Cedar Hill Cemetery & Mausoleum permit.
Departmitmoorts
Imports
any nju 21. Signature of Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the shock, or heart faiture. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ( Examiner HemoRR HAge Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medicai as the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? res 2 No certificate 2□ No 1 Yes 1 Tyes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one examiner? 1 Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 X Inpatient 2 ER/Outpatient 3 DOA this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medicai Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Do056296 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Fracker Speak Drive Beltieve Md 21237 31. Date filed (Month, Day, Year)
DEC 4 9 2005 32. Registrar's Signature State Registra

|   |                     | 1 - For State Registrer  | State of M   | laryland               | Depa<br>Cer                   | artment<br>tificate                         | of H             | ealth a                        | and M                 |  | Reg. No.                  | 05                          | 42069   |
|---|---------------------|--|--|------------------------|-------------------------------|---|------------------|--------------------------------|-----------------------|--|---------------------------|-----------------------------|---|
| Physi   | cian                | Decedent's Name (First, Middle, Las  CLARETTA  |  | AMBLE                  |                               |   |                  |                                |                       | Month                                  | Day                       | Year                        | 1 10 0 1  |
| /Med<br>Exam  |                     | 4a. Fecility Name (If not institution, give  |  |                        |                               | 4b. City, To                                | own, or          | Location of                    | f Death               | Dec.                                   | 24<br>4c. C               | 2005<br>ounty of De         |   |
| LAGII   | **                  | Washington Advent  | ist Hosp   | ital                   |                               | Tako  | ma :             | Park                           |                       |  | Mo                        | ontgon                      | nery  |
| Funera<br>Directo   |                     | 145-34-1448  | 7. A   | ige (In yrs. la        | st birthday)<br>Yrs.          | If Under 1<br>Months                        | Year<br>Days     | If Under<br>Hours              | 24 Hrs.<br>Min.       | 8. Date of Bir<br>(Month, Da<br>Sept 4 | th<br>19, Υθας)<br>• 194  | 2 G                         | irthplace (State or Foreig<br>Country)<br>eorgia                |
| and w.w.  |                     | Usuel Residence of Decedent  10a. State 10b. County  |  | 10c. City              | , Town or Lo                  | cation                                      |                  |                                |                       |  |                           |                             | 10d. Inside City Limits   |
| Maryl<br>-f ehc   | to                  | MD Montgome  | rv   | Та                     | koma 1                        | Park  |                  |                                |                       |  |                           |                             | 1 Yes 2 No  |
| r 28a   | irec                | 10e. Street and Number   |  |                        |                               | 10f. Zip C                                  | ode              |                                |                       |  | 10g. Citize               | n of What C                 | Country?  |
| th wit  | a D                 | 8607 Barron St.  |  |                        |                               | 20  | 912              |                                |                       |  |                           | USA                         |   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Iteme 23a or 28a-f ehow any injury or other traumetic event, the Medical Esternment must be notified at | by Funeral Director | 11. Marital Status  1 Never Married 2 Amarried 3 Widowed 4 Divorced  | 12. Was Deceden<br>Armed Forces<br>1 Yes 2 If Yes, Give<br>Year or Dates | :?<br><b>X</b> No      | 1                             | Was Deceder<br>f Yes, specify<br>1 ☐ Yes 20 |                  | spanic Orion, Mexican Specify: | gin? (Spe<br>, Puerto | ecify Yes or No<br>Rican, etc.)        |                           | Black, Wh                   | nerican Indian,<br>hite, etc.<br>Black                          |
| 72 ho   | eted                | 15. Decedent's Ed<br>(Specify only highest grad  | ucation<br>de completed)   |                        | 16a. Deced                    | ient's Usual (                              | Occupa<br>done d | ition<br>Jurina mosi           | of work               | na                                     | 16b. Kind                 | of Busines                  | s/industry  |
| vithin<br>ne.<br>hen  | Completed           | Elementary/Secondary (0-12)  | College (1-4or   | r 5+)                  |                               | kind of work<br>DO NOT use                  | retired,         | )                              |                       |  |                           |                             | E   |
| Hygie<br>Hygie<br>Ther t  | Ö                   | 17. Father's Name (First, Middle, Last)  | 6+   |                        | Nurs                          | se  |                  | 18 Mothe                       | r's Nama              | First, Middle                          |                           |                             | Hospital (  |
| d be fantal h   | Be                  |  |  |                        |                               |   |                  |                                |                       | Roya1                                  | , 191010011 01            | umamoj                      |   |
| should<br>nd Me<br>mark<br>imeti  | ဥ                   | 19a. Informant's Name/Relationship (7  | ype, Print)  |                        | 19b. Mailir                   | ng Address (5                               | Street a         |                                |                       | NOYAL  Al Route Numb                   | er, City or 1             | rown, State,                | Zip Code)   |
| nd 2<br>alth a<br>27 is   |                     | Joe Gamble/Husban  | d  |                        |                               | Barro                                       |                  |                                |                       | ma Parl                                |                           |                             |   |
| s 1 a<br>of Hea   |                     | 20a. Method of Disposition   |  | 20b. Pla               | ace of Dispo                  | sition (Name<br>natory or othe              | of<br>er place   |                                |                       | Date                                   |                           |                             | r Town, State   |
| Page<br>nent c<br>int: If   |                     | 1 ⊠ Burial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify  |  |                        |                               |   |                  |                                | 2-30                  | -2005                                  | Brent                     | wood,                       | MD.   |
| permit.<br>Departr<br>Imports<br>eny inje   | Suc                 | 21. Signature of Funeral Gervice Ligen:  | shill  | 2                      |                               | arshal<br>217 9t                            |                  |                                |                       | Home,Ii                                |                           | DC. 2                       | 20011   |
| Examine be executed physician and purial-transit es the burial-transit  | ical Examiner       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Hyperte Due to (or a  | s a consequ            | ence of):                     |   |                  |                                |                       |  |                           |                             |   |
| death certif<br>e ettending<br>ed for use as  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcom 1 Live birth 4 Pregnant                              | 2 Fetal                | death 3                       | Ectopic preg                                |                  |                                |                       |  | 23                        | d. Date of de<br>Month      | elivery<br>Day Year   |
| quires that<br>n signed b   | <u>م</u>            | Part II. Other significant conditions or   | ontnbuting to death  | but not resu           | lting in the u                | nderlying cau                               | se give          | n in Part I.                   |                       |  | obacco use<br>Yes 2X      |                             | to the cause of death?  Probably 4 Unknown                      |
| hysician: The law requires that the<br>his certificate has been signed by th<br>I director, page 2 should be detach   | Completed           |  |  |                        |                               |   |                  |                                |                       | 24a. Was<br>auto<br>perfo<br>1 Yes     | psy<br>ormed?             | prior to<br>death?          | autopsy findings available<br>completion of cause of<br>s 25 No |
| Physician:<br>r this certifica<br>ral director, I   | To Be               | 25. Was case referred to medical examiner?  1 1 Yes 2 X No   | Hospital: 1 🖔 Inpat  | tient 2 🗆              | R/Outpation                   | t 3 DOA                                     | Othe             | hr-                            |                       | n <i>(Check only o</i><br>me 5 ☐ Resi  |                           | 7015 (0                     | agrifich.   |
| Attending Phy<br>r death.<br>ector: After this<br>by the funeral of   | atlon: T            |  | 28a. Date of In<br>(Month, D   | jury                   | 28b. Time of<br>Injury        |   | . Injury<br>Work |                                |                       | 28d. Describe                          |                           |                             | өспу)   |
| i git o   | Certification:      |  | building,  | etc. (Specify,         | )                             |   |                  |                                |                       | City or To                             | wn, State)                |                             | Ru <i>ral Route Number</i> ,                                    |
| the Hospital<br>hin 24 hours a<br>the Funeral t<br>npletely filled  | edical              | 29a. Certifier 1 Check party 2 Medical Exam  | rsicien: To the bes<br>iner: On the basis<br>and manners                 | of examinati           | viedge, death<br>on and/or in | n occurred at<br>vestigation, in            | the tim          | e, date an<br>pinion, dea      | d place,<br>th occurr | and due to the<br>ed at the time,      | cause(s) ar<br>date and p | nd manner a<br>lace, and du | as stated.<br>ue to the cause(s)                                |
| To the<br>within 2<br>To the<br>complet   | Σ                   | 29b. Signature and title of certifier  |  |                        |                               | 29c. l                                      | License          | number                         |                       |  | 29d. Date                 | signed (Mor                 | in, Day, Year)  |
| 9   |                     | > > 1)V  | min  | ч.                     |                               | D.  | 5928             | 84                             |                       |  | 12/                       | 241                         | , 101   |
| 0   |                     | 30. Name and address of person who o   | ompleted cause of  | death (Item            | 23а) (Туре,                   | Print)                                      |                  |                                |                       |  |                           |                             |   |
| 2.5   | tate                | S. Shamin, M.D.  31. Date filed (Month, Day, Year)  DEC 2 9 200  | 7600 Ca1   | rro11<br>trar's Signat | Ave !                         | Cakoma                                      | Par              | rk, M                          | D.                    |  |                           |                             |   |

|                                |  | •   | For<br>State<br>Registrer   | State of Marylar  |                                       | tificate of D   |                   |  | g. No.  | 42070  |
|--------------------------------|--|---|---|---|---------------------------------------|---|-------------------|--|---|--|
| jā.                            | Physicia<br>/Medic<br>Examin<br>Funeral<br>Director  | an<br>cal<br>ner                                      | Decedent's Name (First, Middle, Last)   |   |                                       | 2. Date of Death<br>Month<br>December                                       | Dav Year          | 3. Time of Death 22:13 M                   |   |  |
| X.                             |  |   | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Tohns Hopkins Bayview Medical Center Battimore   |   |                                       |   |                   |  |   |  |
| #.                             |  |   | 230 03 2727   | 7. Age (In yrs  | Ven                                   | If Under 1 Year<br>Months Days  | Hours Min.        | 8. Date of Birth<br>(Month, Day,<br>April6 | 9. Bird<br>, 1914<br>, 1914<br>, 1914             | hplace (State or Foreign<br>buntry)<br>hCarolina |
|                                | land<br>ow   |   | Usuel Residence of Decedent           10a. State         10b. County         10c. City, Town or Location  |   |                                       |   |                   |  | 10d. Inside City Limits                           |  |
|                                | d within 72 hours after death with the Maryland<br>Jione.<br>I than "natural", or Itema 23a or 28a-f show<br>The Medical Examinar mout to motified at  |   | MD Baltimore Baltimore  |   |                                       |   |                   |  | 1 Tes 2 No  |  |
|                                |  | Sirec   | 10e. Street and Number  | _   |                                       | 10f. Zip Code   |                   |  | g. Citizen of What Co                             | puntry?  |
| Baltimore, Maryland 21215-0036 |  | To Be Completed by Funeral Director                   | 4044 St. August   |   | IS 13 1                               | 21222   |                   |  | USA<br>14. Race - Ame                             | nican Indian.                                    |
|                                |  |   | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced   | N. Was Decedent Ever in U<br>Armed Forces?<br>1   |                                       | Was Decedent of His<br>f Yes, specify Cubar<br>1 ☐ Yes 2 ☐ No               | Specify:          | Rican, etc.)                               | Black, Whit                                       | e, etc.  |
|                                |  |   | 15. Decedent's Educa<br>(Specify only highest grade   | College (1-4or 5+)  (Give life. E   |                                       | dent's Usual Occupation   |                   |  | 16b. Kind of Business/Industry                    |  |
| 215                            | C * 34   |   | Elementary/Secondary (0-12)   |   |                                       | e kind of work done during most of working<br>DO NOT use retired)<br>Cetary |                   | F  | Koppers C   | lo.  |
| 72                             | filed within Hygiene.  |   | 17. Father's Name (First, Middle, Last)   | -   | peci                                  |   | 18. Mother's Name | e (First, Middle, N                        | Maiden Sumame)                                    |  |
| land                           | og   |   |   |   |                                       |   | Minor             | Minor                                      |   |  |
| ary                            | A DEE  |   | 19a. Informant's Name/Relationship (Type  |   | 19b. Maili                            | ng Address (Street a  | nd Number or Run  | al Route Number,                           | City or Town, State,                              | Zip Code)  |
| N.                             | s 1 and 2<br>if Health a<br>item 27 ls<br>other trai   |   | Loring Glover /   |   |                                       | 26 Agate  |                   |  |   | 1040   |
| ore                            | of of tit  |   | 20a. Method of Disposition  1↓□ Burial 2 □ Cremation 3 □ Rea  4 □ Donation 5 □ Other (Specify)  | moval from State  | cemetery, crei                        | osition (Name of<br>matory or other place<br>ofFaith                        | 9)                |  | 20c. Location - City or ${\sf Rossville}$         |  |
| ĦĦ                             |  |   | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses   |   |                                       | 2. Name and Addres  | s of Esculing     | Ji-  |   |  |
| Ba                             | permit. Departr Imports any inj  |   | R Term  | mal   | 1,                                    |   | Co                |  |   | meofEssex  |
|                                | Physician  |   | 23a. Part1. Enter the disease, or complications that caused the death-foo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Auther renal Gillare  |   |                                       |   |                   |  |   | Approximate<br>Interval Between                  |
| 6                              | /Medical<br>Examiner   |   | resulting in death)   | Due to (or as a consequence of):  Sewis   |                                       |   |                   |  |   |  |
|                                |  | ai Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a consequence of):  |                                       |   |                   |  |   |  |
|                                | ificate be executed<br>g physician and<br>as the burial-transit  |   | Cause (Disease or injury that initiated events c. resulting in death) Last  | Due to (or as a consequence of):  |                                       |   |                   |  |   |  |
| 68760,                         | sician<br>buria  |   |   |   |                                       |   |                   |  |   |  |
|                                | <u>≔</u>   | ledicai   | u.  |   |                                       |   |                   |  |   |  |
| O. Box                         | To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a | Medicai Certification; To Be Completed by Physician/M | IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  | c. If yes, outcome of preg<br>1 □ Live birth 2 □ Fe<br>4 □ Pregnant at time ot<br>9 □ Unknown       | 2 ☐ Fetal death 3 ☐ Ectopic pregnancy |   |                   |  | 23d. Date of delivery<br>Month Day Year           |  |
| , P.O                          |  |   | Part II. Other significant conditions cont  | at conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. |                                       |   |                   | 23e. Did tob                               | Did tobacco use contribute to the cause of death? |  |
| rds                            |  |   |   |   |                                       |   |                   | 1 □ Ye                                     | es 2□No 3□P                                       | robebly 4 QUnknown                               |
| of Vital Records,              |  |   |   |   |                                       |   |                   | 24a. Was a<br>autops<br>perform<br>1 Yes 2 | y prior to<br>ned? death?                         | utopsy findings available completion of cause of |
| /ita                           |  |   | 25. Was case referred to medical examiner?  | 5. Was case referred to medical 26. Place of Death (Check only one)                                 |                                       |   |                   |  |   |  |
| <b>→</b>                       |  |   |   |   |                                       |   |                   |  |   | ecify)   |
|                                |  |   | 1 Natural 5 Pending 2 Accident Investigation  | (Month, Day Year) Injury  |                                       | of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No                                   |                   |  |   |  |
| Division                       |  |   | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At building, etc. (Spec  |                                       | reet, factory, office   |                   | 28f. Location (St<br>City or Town          | reet and Number or R<br>n, State)                 | ural Route Number,                               |
|                                |  |   | 29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                                       |   |                   |  |   |  |
|                                | To the vithin To the Comp  | Me  | 29b. Signature and title of certifier   | 1.  |                                       | 29c. License  |                   |  | 9d. Date signed (Mon                              |  |
| •                              | 0  |   | 1/// Sw   | 1   |                                       | RES   | 000               | D  | ecember   | +,2005   |
| Í                              | 0  |   | 30. Name and address of person who cor  | mpleted cause of death (It  | em 23a) (Type                         | Print)  | WE BY             | 7271MO                                     | er MD   | 21274  |
| 1                              |  |   | 1/1/1-11- 21  | 1170  | 07210                                 | 50 . VOLD   | 00 -1             | , , , , , ,                                |   | -1-4-1   |

Registrar

DEC 2 9 2005 Remain A forth ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 05 State Amend Item #23b Per Phy G850 12429/2056 Jul Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2:00 A. 23, 2005 KTRBY **GLEASON** December ANNA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lutherville College Manor 8. Date of Birth (Month, Day, Yea Sept. 15, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Year) **Funeral** Days Months Hours 1 ☐ M 2 🕅 F Maryland Yrs 1919 86 Sept. 163-16-5862 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 1 Tyes 2X No Director Rodgers Forge Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21212 U.S.A. 53 Murdock Road Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Secretary 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Amos Thomas Hughlett Kirby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21212 53 Murdock Road (daughter) Anne Gleason 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Garden's 12-27-05 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland Shock, or heart failure. List only one cause on each line. 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tailure Zuk enne Physician /Medical Due to (or as a consequence of): Examiner Sepsis

Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed anding physicien and use as the burial-transit Due to (or as a consequence of). Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year ŏ in the past 12 months? 5 Other (specify) 4 Pregnant at time of death signed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy has 2 No Yes certificate Division of Vital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner' Other: Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospitel or Attendii within 24 hours after death. To the Funerel Director: A 2 Accident the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide teritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23076 12-23 00 Vous 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Koal Mil Fulls 730 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 9 2005 Registrar

|                                   |   | ,                       | 1 - For State of Registrer   | Maryland / Der                       | partment of He<br>ertificate of D  |                           | ental Hygie                                 | .000   | 2072   |  |
|-----------------------------------|---|-------------------------|--|--------------------------------------|--|---------------------------|---|--|--|--|
|                                   | Physici<br>/Medic<br>Examin   | cal                     | 4a. Facility Name (If not institution, give street and numb  | DDMAN, 5                             | 4b. City, Town, or I   |                           | 2. Date of Death Month 7                    | Day Year 2005                                  | 3. Time of Death 2200 M  |  |
|                                   | Funeral   | ier                     | 5. Social Security Number 6. Sex XXX 200 7   | Age (In yrs. last birthda<br>81 Yrs. | COLUR  | NBIA If Under 24 Hrs.     | 8. Date of Birth                            | HOW A  | place (State or Foreign  |  |
| e, Maryland Z1Z15-UUSb            | n 72 hours after death with the Maryland  "natural", or Itams 23a or 28a-f show  calcal Examinar mart be natified at                | rai Director            | 218-14-5466  | 10c. City, Town or  Marric           | ottsville<br>  10f. Zip Code<br>  21104  |                           | 10g.<br>Unit                                | Ma   | ryland  10d. Inside City Limits  1  Yes 2 No  Intry?  of America |  |
|                                   |   | leted by Funeral        | 11. Marital Status  1 Never Married 2 Married  1 Yes Give  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)   | No<br>es:                            | 3. Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 ☒ No cedent's Usual Occupative kind of work done du. DO NOT use retired). | Specify:                  |   | 14. Race - Amer<br>Black, White<br>Specify: Wh | ite  |  |
|                                   | be filed within that Hygiene. od other then event, the M  | o Be Completed          | Elementary/Secondary (0-12) College (1-4) 12 0  17. Father's Name (First, Middle, Last)  William Blazzey Godman  | or 5+) Mast                          | ter Electri  | cian<br>18. Mother's Name | (First, Middle, Mai                         | ,  | ed   |  |
|                                   | permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is markr any Injury or other traumatic <u>once.</u> | То                      | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Charmaine Euler (Step-Daughter) 1912 Suffolk Road, Finkshir Maryland 21048  20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20b. Place of Disposition (Name of cemetery, crematory or other place)   4 Donation 5 Other (Specify)   Woodlawn Cemetery   12/29/05   Woodlawn, Maryland   22. Name and Address of Facility Loring Byers Funeral Directors, In |                                      |  |                           |   |  |  |  |
| of Vital Records, P.O. Box 68/60, | Physician<br>/Medical<br>Examiner   | Examiner                | 23a. Part Lenter the disease, of complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)  |                                      |  |                           |   |  |  |  |
|                                   | at the death certificate be executed by the attending physicien and stached for use as the burial-transit                           | Physician/Medical Exa   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  d.  23c. If yes, outcomes the pregnant in the past 12 months? 4 ☐ Pregnant in the past 12 months? 9 ☐ Unknown   | nt at time of death s                | 3 □Ectopic pregnancy<br>5 □ Other (specify)  |                           |   | 23d. Date of delive Month                      | Day Year   |  |
|                                   | . The law requires that the of<br>ate has been signed by the<br>page 2 should be detached   | Completed by F          | OBSTRUCTIVE LUNG DISEASE   |                                      |  |                           | 1 Yes<br>24a. Was an<br>autopsy<br>performe | autopsy prior to completion of cause of death? |  |  |
|                                   | hysician:<br>this certifica<br>al director, p   | Certification; To Be Co | 25. Was case referred to medical examiner?  1  |                                      |  |                           |   |  |  |  |
|                                   | To the Hospital or Attanding I within 24 hours after death.  To the Funeral Diractor: After completely filled in by the funer       | Medical Certif          | 29a. Certifier  (Check only one)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                      |  |                           |   |  |  |  |
|                                   | Toth within   | M                       | 29b. Signature and the of certifier  30. Name and address of person who completed cause  | of death (Item 23a) (Typ             | 29c. License D2 (29c. Print)   | 9909                      | 0   | Date signed (Month, &C. 27                     | 2005   |  |
|                                   | Sta<br>Registi  |                         | 20111  | gistrar's Signature                  | lack)  | ,,~ ,*                    | ULIZN W                                     | אין טיטען אינען                                | LI 'S D  |  |

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|             |  |                               | 1 - For<br>State<br>Registrar   | State of Maryland   | d / Depa                             |  | lealth and i   | Mental Hy                              | giene 05<br>Reg. No.                        | 42074   |
|-------------|--|-------------------------------|---|---|--------------------------------------|--|--|--|---|---|
|             | Physici<br>/Medic<br>Examir  | cal                           | Decedent's Name (First, Middle, La     Aa. Facility Name (If not institution, given the control of the con | vertler   |                                      | 4b. City, Town, o  | r Location of Death  | 2. Date of Dea                         | 25 200<br>4c. County of D                   | Death   |
|             | Funeral<br>Director  |                               |   | 6ex 7. Age (In yrs. Ia:   | st birthday)<br>Yrs.                 | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                             | (Month, Da                             | h<br>y, Year) 9.                            | N/A<br>Birthplace (State or Foreign<br>Country)<br>st Virginia                                      |
|             | r 28e-f show   | rector                        | 10a. State 10b. County  | N/A   | Balt:                                | imore  10f. Zip Code   |  |  | 10g. Citizen of Wha                         | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No t Country?   |
| 920         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland<br>Department of Health and Mental Hygiene.<br>Importent: if Item 27 is marked other then "natural", or Items 23a or 28e-f show<br>important of the treumatic event, the Medical Examiner must be routified at<br>20128. | Completed by Funeral Director | 6040 Yorkshire  11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced   | Drive  12. Was Decedent Ever in U.S. Amed Forces? 1 □ Yes 2 NWXX If Yes, Give Year or Dates:                              |                                      | 21<br>Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🌠 No          | 212<br>lispanic Origin? (Span, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>o Rican, etc.)    | USA<br>14. Race - A<br>Black, V<br>Specify: | American Indian,<br>Vhite, etc.   |
| 21215-0036  | filed within 72 ho<br>Hygiene.<br>other then "naturi<br>ent, the Medical I   | Completed                     | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0-12)   | ducation<br>ade completed)  College (1-4or 5+)  |                                      | dent's Usual Occup<br>kind of work done<br>DO NOT use retired<br>Ails Cler |  | king                                   | Baltimor<br>Police                          | e County  |
| Maryland    | 2 should be filed within<br>and Mental Hygiene.<br>Is marked other then<br>eumatic event, the M  | To Be (                       | 17. Father's Name (First, Middle, Las.  Linburn   | Blackburn   |                                      |  | 18. Mother's Nam Mabel                                     | ne (First, Middle,                     | Maiden Sumame) Peyton                       |   |
|             | Pages 1 and 2 sho<br>nent of Health and I<br>ent: if Item 27 is m  |                               | 19a. Informant's Name/Relationship  Sharon Lee Guert  20a. Method of Disposition  1 □ Buriai 2 ▼Cremation 3   | Ler 20b. Pla  | 6040<br>ace of Dispo<br>metery, crea | Yorkshir<br>osition (Name of<br>matory or other place                      | e Drive,   | Baltimo<br>Date                        | 20c. Location - City                        | and 21212<br>or Town, State   |
| Baltimore,  | permit. Pag<br>Department<br>Importent:<br>any Injury c  |                               | *4 □ Donation 5 □ Other (Special Service Lines)   | (fy) Gree   | 2                                    | Name and Addre   | ss of Facility   | J There                                | 1 Hama T                                    | , Maryland<br>nc.<br>d 21212  |
| 760,        | wires that the death certificate be executed signed by the attending physician and color of the attending physician and color of the detached for use as the burial-transit  | ilcai Examiner                | Martin D. Li  23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence) | ence of):                            | er the mode of dyin  | ig, such as cardiac  | or respiratory ar                      | rest,                                       | Approximate Interval Between Onset and Death  |
| P.O. Box 68 | the death certific<br>y the attending p<br>ched for use as   | by Physician/Med              | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 1√0 9 □ Unknown  | 23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetel d 4 □ Pregnant at time of dea 9 □ Unknown                       | death 3                              | Ectopic pregnancy Other (specify)  | ,  |  | 23d. Date of<br>Month                       | delivery<br>Day Year  |
| Records, P  | v requ   | Completed by PI               | Part II. Other significant conditions  Preun  | terde De  | ting in the u                        | 1  | en in Part I.  |  | res 2 □ No 3 □                              | e to the cause of death?  Probably 4—Unknown a autopsy findings available to completion of cause of |
| of Vital R  | ding Physicien: The lav<br>h.<br>After this certificate has<br>funeral director, page 2  | To Be Com                     | 25. Was case referred to medical examiner? 1 ☐ Yes 2☐ NO  | Hospital: 1 Intripatient 2 □ E  | R/Outpatier                          | it 3□ DOA Oth  | 26. Place of Dea   | perfor<br>1 ☐ Yes<br>th (Check only or | med? death                                  | n?<br>Yes 2□ No   |
| Division of | Attending r death. ector: After by the fune  | Certification; 1              | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not to determined   | (Month, Day Year)   | 28b. Time o<br>Injury                | M 1  | y at   | 28d. Describe h                        | ow injury occurred                          | r Rural Route Number.   |
|             | To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in I  | Medical C                     | 29a. Certifier 1 Certifying Pi<br>(Check only one) 2 Medical Exe  | hysician: To the best of my knowl<br>miner: On the basis of examinatio<br>and manner stated.                              | rledge, deatl                        | n occurred at the tin<br>vestigation, in my o                              | ne, date and place,<br>pinion, death occur                 | and due to the ored at the time, or    | cause(s) and manner<br>date and place, and  | r as stated.<br>due to the cause(s)   |
| )           | To th<br>withir<br>To th<br>comp   | Me                            | 29b. Signature and title of certifier   | ta MIS  |                                      | 29c. Licens  | e number   |  | 29d. Date signed (M                         | ~   |
|             | V  |                               | 30. Name and address of person who  | completed cause of death (Item 2  | 23a) (Type.                          |  |  |  |   | 51530   |
|             | Sta  | ate                           | 31. Date filed (Month, Day, Year)   | 2. Registrar's Signatu  | ire .                                |  |  |  |   |   |

|                              |  |                   | For<br>State<br>Registrar   | State of Mar   |   | artment<br>rtificate                            |                         |   | nd Me                |  | iene<br>g. No.              | 15 - 4   | 2075   |
|------------------------------|--|-------------------|---|--|---|---|-------------------------|---|----------------------|--|-----------------------------|--|--|
| 43                           | Physici  | an                | Decedent's Name (First, Middle, Last  |  | - : 0                                     |   |                         |   |                      | 2. Date of Death<br>Month                    | Day                         | Year   | 3. Time of Death 9:17AM                                  |
|                              | /Medic<br>Examin   | al                | Ervin Corne<br>4a. Facility Name (If not institution, give<br>1431 Preston Str  | street and number)   | rrb                                       | , ,   |                         | Location of                             |                      | 12   | 4c. Cou                     | 2008<br>nty of Death                                       | -11,12   |
| ₹.<br>₹.                     | Funeral<br>Director  |                   | 5. Social Security Number 6. Se 215 • 58 • 1386                                 | x 7. Age (<br>✓ M 2 F  | In yrs. last birthday) 52 Yrs.            | If Under<br>Months                              | 1 Year<br>Days          | If Under 24<br>Hours                    | Min.                 | 8. Date of Birth (Month, Day,                | Year)<br>1953               | 9. Birthp<br>Coun  | lace (State or Foreign<br>try)                           |
| death with the Maryland      | -f ehow<br>fied at   | tor               | Usual Residence of Decedent  10a. State  10b. County  A  A                      | 1  | Oc. City, Town or Lo                      |   | <br>ک                   |   |                      | <u></u>                                      |                             | 10   | 0d. Inside City Limits                                   |
| with the                     | 3a or 28   | i Director        | 10e. Street and Number  | reet   |   | 10f. Zip  |                         | 203                                     |                      | 10   | _                           | NSA  | try?   |
| - G                          | e.<br>en "naturel", or iteme 23a or 28a-f ehow<br>Medical Examiner must be notified at   | by Funeral        | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced              | 12. Was Decedent Ev<br>Armed Forces?<br>1 ☐ Yes 2 Stool<br>If Yes, Give<br>Year or Dates:  |   | Was Deced                                       | rfy Cuban               | spanic Origi<br>i, Mexican,<br>Specify: | n? (Spec<br>Puerto R | ofy Yes or No-<br>lican, etc.)               | 8                           | lace - Americ<br>lack, White, o                            | etc.   |
| Z idi                        | 8 = 3  | Completed         | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12) | cation<br>le completed)<br>College (1-4or 5+)  | (Give                                     | dent's Usua<br>kind of wor<br>DO NOT us<br>CUCK | k done di<br>e retired) | uring most of                           |                      | g  |                             | NS POV   | tation   |
| aryland 2<br>should be filed | la p   | To Be C           | 17. Father Name (First, Middle, Last) Sam C. Ham                                |  |   |   |                         | Edi                                     | th                   | (First, Middle, N                            | att                         |  |  |
| <b>E</b> 5                   | t Health and Meritem 27 is marked other traumatic  |                   | Jeanine Hams  | Daughte  | r 13A                                     | mbo   | Civ                     | de                                      | CI                   |  | MD:                         | 21220  |  |
| Saltimore,                   | 0  |                   | 20a. Method of Disposition  1 Burial 2 Commation 3 4 Donation 5 Other (Specify, |  | 20b. Place of Dispo<br>cometery, createry |   |                         |   |                      |  |                             | in - City or To<br>でかいへ                                    |  |
| Balt                         | Department<br>Important: I<br>eny injury o   |                   | 21. Signature of Funeral Service Licens   | Suit   |   | Name and  | d Address               | Bree<br>Bree                            | ne F<br>Ba           | uneral<br>Ito MD                             | sen<br>212                  | lice<br>12   |  |
|                              | hysician physician and physician and physician the price transit trans | licai Examiner    | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | a. CAYCING  Due to (or as a of the control of the c | 0   | er the mode                                     | 1                       | ynx                                     | ardiac or            | respiratory arre                             | est.                        | <b>✓</b>   | Approximate Interval Between Onset and Death             |
| . BOX b                      | e attending p  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No        | 23c. If yes, outcome of<br>1 ☐ Live birth 2<br>4 ☐ Pregnant at tir<br>9 ☐ Unknown  | Fetal death 3                             | Ectopic pro                                     |                         |   |                      |  |                             | Date of delive<br>Month                                    | ry<br>Day Year   |
| ecords, P.O                  | been signed by the a<br>should be detached to  | þ                 | Part II. Other significant conditions co  | ntnbuting to death but   | not resulting in the u                    | nderlying ca                                    | ause give               | n in Part I.                            |                      |  | acco use c                  |  | e cause of death? ably 4 Unknown                         |
| r                            | page   | Completed         |   |  |   |   |                         |   |                      | 24a. Was ar<br>autopsy<br>perform<br>1 Yes 2 | n 24<br>y<br>ned?           | b. Were autop<br>prior to con<br>death?<br>1 \( \text{Yes} | osy findings available<br>npletion of cause of<br>2   No |
| VIT                          | is certificate<br>director, pag  | o Be              | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ♣ No                      | Hospital:<br>1 ☐ Inpatient   | 2 ER/Outpatie                             | 2 2 00  | Othe                    |   |                      | (Check only one                              |                             | Othor (Coost   | 4  |
| on of                        | h.<br>After this<br>funeral di   | tion: To          | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation               | 28a. Date of Injury<br>(Month, Day)  |   |   | 8c. Injury<br>Work      |   | 28                   | 8d. Describe ho                              |                             |  | //   |
| DIVISION OF VITA             | within 24 hours after death.  To the Funerei Director: After completely filled in by the funer   | Certification:    | 3 Suicide 6 Could not be determined   | 28e. Place of Injury<br>building, etc.   | y - At home, farm, st<br>(Specify)        | reet, factory                                   | , office                |   | 21                   | 8l. Location (Str<br>City or Town            |                             | m <i>ber</i> or Rura                                       | l Route Number,  |
| E COOL                       | within 24 hours a To the Funerei t completely filled   | Medicai (         | 29a. Certifier (Check only one) 2 Medical Exem                                  | sicien: To the best of<br>iner: On the basis of e<br>and manner state  | xamination and/or in                      | h occurred a vestigation,                       | at the time<br>in my op | e, date and<br>inion, death             | place, ar<br>occurre | nd due to the ca<br>d at the time, da        | use(s) and<br>ate and place | manner as st   | ated.<br>the cause(s)                                    |
| Total                        | Tota   | Σ                 | 29b. Signature and title of certifier   | )  |   | 1   | License                 |   | 0                    |  | _                           | ber 2  |  |
|                              | 1/   |                   | 30. Name and address of person who of   | ompleted cause of dea<br>Richey Un   | th (Item 23a) (Type,                      | Print)  | VEL                     | itaw                                    | St                   | Balti  | mere                        | MD.  | 8,2005   |
| 1914                         | Sta  | ate               | 31. Date filed (Month, Day, Year)   | 32. Figistrar  | s Signature                               | Carte   | ,                       |   |                      |  |                             |  |  |

|                            |   |                     | For<br>State<br>Registrar  | State of M  | larylan     | -   |                                    |                       | lealth a<br>Death                       | and M                   | _                               | giene<br>Reg. No.                | )5                                       | 12076  |
|----------------------------|---|---------------------|--|---|-------------|---|------------------------------------|-----------------------|---|-------------------------|---------------------------------|----------------------------------|--|--|
|                            | Physici   | an                  | 1. Decedent's Name (First, Middle, La.   |   |             |   |                                    | 1+A V                 | -                                       | -                       | 2. Date of De<br>Month          | ath<br>Day                       | Year                                     | 3. Time of Death                                 |
|                            | /Medic<br>Examin  | al                  | 4a. Facility Name (If not institution, giv   |   |             | r. 0  | _                                  | , Town, or            | Location o                              | Death                   | DECEMBI                         |                                  | nty of Death                             | 23:07 M  |
|                            | Funeral   | 4                   | JOHNS HOPKINS BAYUL<br>5. Social Security Number 6. S  |   |             | last birthday)  |                                    |                       | If Under 2                              |                         | 8. Date of Bir                  | th                               | N/A<br>9. Birthi                         | place (State or Foreign                          |
|                            | - Funeral Director  |                     |  | □M 2 <b>X</b> )F  |             | 80 Yrs.   | Months                             | Days                  | Hours                                   | Min.                    | (Month, Da<br>SEPT 9            | , 1925                           | Cou                                      | ssouri   |
|                            | and   |                     | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. Cit    | ty, Town or Lo  | cation                             |                       |   |                         |                                 |                                  |  | 10d. Inside City Limits                          |
|                            | Mary<br>Find  | tor                 | MD Balt  | imore   |             |   |                                    | Ва                    | ltim                                    | ore                     |                                 |                                  |  | 1 ☐ Yes 2 No                                     |
|                            | or 28   | Jirec               | 10e. Street and Number   |   |             |   | 10f. Zi                            | p Code                |   |                         |                                 | 10g. Citizen o                   | of What Cou                              | ntry?  |
|                            | ath w   | rai                 | 1046 Old Nor   | ,   |             |   |                                    |                       | 212                                     |                         |                                 | 1                                | USA                                      |  |
| 36                         | permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other then "natural", or Iteme 23s or 28e-f show any injury or other traumatic event, if a Madical Examiner must be notified at once.  | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Marned  3 □ Widowed 4 ☒ Divorced   | 12. Was Decedent Armed Forces 1 Tes 2 Tes If Yes, Give Year or Dates: | ?           |   | Was Dece<br>If Yes, spe<br>1 ☐ Yes |                       | ispanic Orig<br>in, Mexican<br>Specify: | gin? (Spe<br>, Puerto l | cify Yes or No<br>Rican, etc.)  |                                  | ace - Americack, White,                  |  |
| 21215-0036                 | 72 hou  | ted                 | 15. Decedent's Ed<br>(Specify only highest gra   | ducation  |             | 16a. Dece   | dent's Usu                         | al Occupa             | ation<br>during most                    | of working              |                                 | 16b. Kind of                     |  |  |
| 2                          | vithin 7  | Completed           | Elementary/Secondary (0-12)  | College (1-4or  | 5+)         | life.   | DO NOT I                           | ise retired           | )                                       | . OF WOTKII             | ig                              |                                  |  |  |
| 15<br>D                    | filed v<br>Hygie<br>ther t  | CO                  | 17. Father's Name (First, Middle, Last)  |   |             | Ве  | auti                               | cla                   |   | r's Name                | (First Middle                   | Hair                             |  | on   |
| Maryland                   | id be<br>lental<br>rkad o   | To Be               | Richard  |   | C           | Calver  | t                                  |                       |   | Alio                    |                                 |                                  |  | Unk.   |
| lary                       | shou<br>and N<br>is mar   |                     | 19a. Informant's Name/Relationship (   | Type, Print)  |             |   |                                    | s (Street a           |   |                         |                                 | er, City or Tow                  | m, State, Zip                            |  |
|                            | and and in 27 m 27 her tr   |                     | Alice I. Schmi   | ncke, da  |             |   |                                    |                       | e Ave                                   |                         |                                 | timore                           |  |  |
| Baltimore,                 | nt of H   |                     | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐  | Removal from State  | .   0       | Place of Dispondence of Crest | natory or                          | other plac            |   |                         | ate                             | 20c. Location                    |  |  |
| 틅                          | artme<br>ortani<br>injury   |                     | 4 Donation 5 Other (Specification 21. Signature of Funeral Service Licer   |   |             |   |                                    |                       |   |                         |                                 |                                  | T L TIHO                                 | re, MD   |
| ä                          | Depariment Deparement |                     | > Ses E  | Marke   | 1           |   | rema<br>99 F                       | tion<br>reder         | Socie<br>Socie                          | ety c<br>Road           | of MD,                          | Inc.<br>more. 1                  | vm 21                                    | .228   |
|                            | Physician   |                     | Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition | one cause on each l   | ine.        | th. Do not ent  | er the mod                         | de ol dyini           | g, such as o                            | cardiac o               | r respiratory a                 | rest,                            |  | Approximate Interval Between Onset and Death     |
|                            | /Medical<br>Examiner  |                     | resulting in death)  | Due to (or as   |             | . ,   | 200                                | / 0/1                 | CLACE                                   |                         |                                 |                                  |  | a supplement                                     |
| 18.                        |   | e                   | Sequentially list conditions, if any, leading to immediate   | b. Due to (or as  |             | RY A  | JEK-1                              | 013                   | とおうと                                    |                         |                                 |                                  |  | MONEY  |
| i                          | cuted<br>nd<br>ransit   | Examiner            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                      | c   |             |   |                                    |                       |   |                         |                                 |                                  |  |  |
| 8760,                      | icate be executed<br>physicien and<br>s the burial-transit  |                     | resulting in death) Last   | Due to (or as   | a conseq    | quence ol):   |                                    |                       |   |                         |                                 |                                  |  |  |
| 687                        | ficate<br>physics the   | edicai              |  | d   |             |   |                                    |                       |   |                         |                                 |                                  |  |  |
| P.O. Box                   | The law requires that the death certificate be executed ete has been signed by the ettending physicien and page 2 should be detached for use as the burial transit  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown                                  | 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown              | 2 Feta      | al death 3  | Ectopic p<br>Other (s              |                       |   |                         |                                 |                                  | Pate of deliver<br>Month                 | ary<br>Day Year                                  |
|                            | ires that t<br>signed by<br>d be detai  | by                  | Part II. Other significant conditions of   | ontributing to death t  | out not res | sulting in the u  | nderlying o                        | ause give             | en in Part I.                           |                         |                                 | /                                |  | ne cause of death?                               |
| Ö                          | w requir<br>been sl<br>should   | eted                |  |   |             |   |                                    |                       |   |                         | 10                              |                                  |  | ably 4 Unknown                                   |
| Division of Vital Records, | ysician: The lav<br>is certificete has<br>director, page 2:   | Completed           |  |   |             |   |                                    |                       |   |                         | 1 ☐ Yes                         | rmed?<br>2 No                    | prior to co<br>death?<br>1 \(\sum \) Yes | psy findings available mpletion of cause of 2 No |
| ₹                          | rsicia<br>s certi<br>directo  | То Ве               | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital: 1 Inpati  | ent 2       | ER/Outpatien  | t 3 🗆 D(                           | Othe                  |   |                         | (Check only o                   | in <i>e)</i><br>dence 6 □O       | Ab == /C b                               |  |
| סר                         | ng Phy<br>ter thi<br>neral o  | T: L                | 27. Manner ol Death  | 28a. Date of Inju   |             | 28b. Time of<br>Injury  |                                    | 28c. Injury<br>Work   | 7 🗀 1101                                |                         |                                 | now injury occu                  |  | <u>//</u>  |
| Sior                       | eath.<br>or: Af<br>the fur  | catlc               | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be  |   |             |   | М                                  | 101                   | res 2 □ N                               | 10                      |                                 |                                  |  |  |
| Ω                          | To the Hospital or Attending Physician: within 24 hours after death. To the Funerei Director: Atter this certifice completely filled in by the funeral director, is   | Certification:      | 4 Homicide determined  | building, e   | tc. (Specif | (y)   |                                    |                       |   |                         | City or Tox                     | vn, State)                       |  | if Route Number,                                 |
|                            | Hosp<br>24 hou<br>Fune<br>stely fil   | Medical             | 29a. Certifier 1 Cartifying Ph<br>(Check only 2 Medical Examone)   | ysician: To the best<br>ninar: On the basis of<br>and manner si       | x examina   | owledge, death<br>ation and/or inv  | occurred<br>vestigation            | at the time, in my op | e, date and<br>pinion, deatl            | d place, a<br>h occurre | and due to the aid at the time, | cause(s) and n<br>date and place | nanner as s<br>e, and due to             | tated.  the cause(s)                             |
|                            | vithin<br>Fo the  | Me                  | 29b. Signature and title of certifier  | and marrier s   |             |   | 29                                 | c. License            | number                                  |                         |                                 | 29d. Date sign                   | ned (Month,                              | Day, Year)                                       |
| )                          |   |                     | Ilnu Sacrel 9  | Malek, Meac   | AL 00       | CTOR  |                                    |                       | aes-0                                   | 000                     |                                 | DECEMB                           | ER 23.                                   | , 2005   |
|                            | \   |                     | 30. Name and address of person who   | completed cause of  | death (Item | n 23a) (Type,   | Print)                             | Actro                 | A L Aum                                 | nct IC                  | Can - A.                        | nc as A                          | 1001                                     | (N ) 17 7 14                                     |
|                            | Sta   | to                  | ADNAN MALIK, JOHN<br>31. Date liled (Month, Day, Year)   | 32. Ragist  | rar's Signa |   | 170 0                              | 2/18                  | NAVE                                    | ישרו                    | DALIM                           | MC, MA                           | -TC/HN                                   | U diddy  |
|                            | Registr   |                     | DEC 2 9  | 2005  | . an a      |   | marke                              | -                     |   |                         |                                 |                                  |  |  |

|                |  |                  | 1 - For Registrar  1. Decedent's Name (First, Middle, Last)   | State of Maryland  | l / Depa                             |  | ealth and                               | Mental Hygi                                       | g. No.  | 12077   |
|----------------|--|------------------|---|--|--------------------------------------|--|---|---|---|---|
|                | Physici<br>/Medic<br>Examir  | cal              | M.C.  4a. Facility Name (If not institution, give   | street and number)   | Har                                  | 4b. City, Town, or   |   |   | Day Year 5 2005 4c. County of Dea                             | 3. Time of Death  12:25p M th                         |
|                | Funeral<br>Director  |                  | Joseph Richy Hosp  5. Social Security Number  438–22–9569  Usual Residence of Decedent  |  | st birthday)<br>Yrs.                 |  | imore If Under 24 Hrs. Hours Min.       | 8. Date of Birth (Month, Day,                     | Year) Co  | thplace (State or Foreign<br>buntry)<br>La.           |
|                | within 72 hours after death with the Maryland<br>ane.<br>Then "natural", or lieme 23a or 28a-f ehow<br>to MacTeal Examinat must be notified at                     | ector            | 10a. State 10b. County  Md . N  10e. Street and Number  |  | Town or Lo                           | imore  |   | 10  | ng. Citizen of What Co  | 10d. fnside City Limits  XXYes 2 □ No                 |
|                | ne 23a or<br>must be   | Funeral Director | 406 Swale Road  | 12. Was Decedent Ever in U.S   | . 13                                 | 21225  |   |   | USA  14. Race - Ame   |   |
| 2000           | n 72 hours after death with the Maryla<br>"natural", or fleme 23a or 28e-f ehov<br>alted Extending mant be maillied at   | ξ                | 1 ☐ Never Married 22 Married 3 ☐ Widowed 4 ☐ Divorced   | Amed Forces? 1  Yes 2  No If Yes, Give Year or Dates:                                    |                                      | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2√ No      | Specify:                                | o Rican, etc.)                                    | Black, Whit   |   |
| 0500-61717     | be fited within 72 hatal Hygiene. Id other then "nati  | Completed        | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | cation<br>e completed)<br>Coltege (1-4or 5+)   | (Give<br>life.                       | dent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | lurina most of wor                      | rking   | 6b. Kind of Business  |   |
| Maryland       | should be filed within and Mental Hygiene. I marked other then umatic event, the M   | To Be C          | 17. Father's Name (First, Middle, Last) Hiram   | Harr   | is                                   |  | Ella                                    |   | John  | son   |
| altillore, Mar | ss 1 and 2 sof Health ar item 27 is cother trau  |                  | 19a. Informant's Name/Relationship (Ty.  Annie Harris 20a. Method of Disposition  Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)                  | Wife 20b. Pla cer  | 40<br>ce of Disponetery, crem        | Swale R sition (Name of natory or other place)  ill Cem.         | oad, Bal                                | timore, N   | City or Town, State, 21225 Oc. Location - City or  Anne Arune | Town, State   |
| Dall           | permit. Page<br>Department of<br>important: #<br>eny injury or<br>once.  |                  | 21. Signature of Funeral Service Licens   |  | s of Facility  East                  | Baltin   | nore, Md.<br>North Ave                  | 21202   |   |   |
|                | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or complishock, or heart faifure. List only or Immediate Cause (Final disease or condition resulting in death)           | Due to (or as a conseque   | Cano                                 |  | g, such as cardiac                      | or respiratory arre                               | st,   | Approximate<br>Interval Between<br>Onset and Death    |
| ,000           | The law requires that the death certificate be executed to has been signed by the attending physician and cage 2 should be detached for use as the burial-transit. | dicat Examiner   | Sequentially list conditions, fary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseque  Due to (or as a conseque                                       |                                      |  |   |   |   |   |
| . c c c        | at the death certific<br>by the attending pl<br>tached for use as t  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  | 3c. ff yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetaf of 4 ☐ Pregnant at time of dea  | leath 3                              | Ectopic pregnancy Other (specify)                                |   |   | 23d. Date of del<br>Month                                     | ivery<br>Day Year                                     |
| 1 (2)          | w requires that<br>been signed b<br>should be deta   | þ                | Part II. Other significant conditions con   | stributing to death but not result   | ing in the u                         | nderlying cause give   | n in Part I.                            |   | acco use contribute to  | the cause of death?                                   |
|                |  | Completed        |   |  |                                      |  |   |   | prior to death?<br>Z No 1 ☐ Yes                               | atopsy findings available completion of cause of 2 No |
|                | ng Physica<br>fer this cer<br>neral direct   | ion: To Be       | 27. Manner of Death  1 Natural 5 Pending  | ospital: 1 Inpatient 2 E   | R/Outpatien<br>8b. Time of<br>Injury | 28c. Injury<br>Work  | r: 4 ☐ Nursing H<br>at<br>?             | th Check only one ome 5 Resider 28d. Describe how | ce 6 Other (Spec  | city) Hospice   |
| II NISIOI      | Atten<br>r deat<br>ector:<br>by the  | Certification:   | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Injury - At hom<br>building, etc. (Specify)                                | e, farm, str                         | -  | 'es 2 □ No                              | 28f. Location (Stre<br>City or Town,              | eet and Number or Ru<br>State)                                | iral Route Number,                                    |
|                | he Hospital or<br>in 24 hours afte<br>he Funeral Dir<br>pletely titled in  | edical           | 29a. Certifier (Check only one) 1 Certifying Frys   | ician: To the best of my known<br>her: On the basis of examination<br>and manner stated. | auga, death<br>in and/or in:         | vestigation, in my op  | e, data and place<br>inion, death occur | , and due to the cac<br>rred at the time, dat     | e and place, and due  | stated.<br>to the cause(s)                            |
|                | To the To the To the Complet   | M                | 29b. Signature and title of certifier   |  |                                      | 29c. License   |   | Į   | Date signed (Month  |   |
| 4              | ler  |                  | 30. Name and address of person who co<br>E. Tso MD Richa<br>31. Date filed (Month, Qay, Year)   | mpfeted cause of death (Item 2  Whospice 8  232. Registrar's Signatu                     | 38                                   | N. Entar   | St Ba                                   | altimore  | kcember 2<br>MD Zi  | 201   |
|                | Sta<br>Registr   |                  | DEC 2 9 2005  | Je. Progistial's Signatu   | 6004                                 |  |   |   |   |   |

|              |  |                  | 1 - State of Maryland / D  | Department of H<br>Certificate of                   |   | ental Hygie                                      |                     | 42078  |
|--------------|--|------------------|--|---|---|--|---------------------|--|
|              | Db. initial  |                  | 1. Decedent's Name (First, Middle, Last)   |   |   | 2. Date of Death<br>Month                        |                     | 3. Time of Death   |
|              | Physicia<br>/Medic   |                  | Agnes Marie Hancock  |   |   | December   | 27, 20              | 105 12:35 P M  |
|              | Examin   | er               | 4a. Facility Name (If not institution, give street and number) Gilchrist Nursing Center  | 4b. City, Town, o                                   | or Location of Death                          |  | 4c. County of Balti |  |
| ¥.           | Funeral<br>Director  |                  | ZZO ZO 1803 / 78   | hday) tf Under 1 Year<br>Months Days                |   | 8. Date of Birth<br>(Month, Day, Yo<br>March 18, | , 1927              | 9. Birthplace (State or Foreign<br>Country)<br>Maryland                |
|              | and **   |                  | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town   | or Location   | · · · · · · · · · · · · · · · · · · ·         |  |                     | 10d. Inside City Limits  |
|              | th with the Marylan<br>23a or 28a-f show   | Ď                |  | Baltimore   |   |  |                     | 1 ☐ Yes 2 🙀 No   |
|              | r 28a  | rec              | 10e. Street and Number   | 10f. Zip Code                                       |   | 10g.   | Citizen of Wi       | nat Country?   |
|              | th wit   | aiD              | 9411 Horn Avenue   | 21  | 236   |  | u.s.                | A.   |
|              | ter dea  | Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | 13. Was Decedent of H<br>If Yes, specify Cuba       | Hispanic Origin? (Spe<br>ean, Mexican, Puerto | cify Yes or No-<br>Rican, etc.)                  |                     | - American Indian,<br>, White, etc.                                    |
| 36           | rs afte  | by F             | 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  | 1 ☐ Yes 2 🕱 No                                      | Specify:                                      |  | Specify:            | White  |
| 21215-0036   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther then "natural", or Items 23a or 28a-f show<br>ther, ite Medical Examinar must be notified at | ted              | 15. Decedent's Education 16a.  | Decedent's Usual Occup                              | pation  | 168  | p. Kind of Bus      | iness/Industry   |
| 215          | d within 7<br>piene.<br>r than "n  | Completed        | Elementary/Secondary (0-12)   College (1-4or 5+)   | (Give kind of work done<br>life. DO NOT use retired | during most of worki<br>d)                    |  |                     |  |
|              | a filed w<br>if Hygier<br>other th   |                  | 10th Grade C   | llerk   | 40 Markada Nasa                               |  | Retail              |  |
| Maryland     | e d la b   | o Be             | Theodore Palmisano   |   | Agnes   | (First, Middle, Mai<br>Wheele                    |                     | )  |
| aryl         | S D E E  | To               | 19a. Informant's Name/Relationship (Type, Print) 19b.  | Mailing Address (Street                             |   |  |                     | tate, Zip Code)  |
| Ž            | 1 and 2 s<br>Health ar<br>tom 27 le  |                  | Mr. Charles Hancock (husband) 9  | 411 Horn Av   | enue, Bal                                     | timore, M  | ID 212              | 36   |
| Se Se        | pes 1 and<br>of Healt<br>if Item 2<br>or other   |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of cemetery   | Disposition (Name of<br>y, crematory or other place | ce)   | ate 200  | . Location - C      | tity or Town, State  |
| Eim 5        | Pag<br>tment<br>tant:  |                  | 4 □ Donation 5 □ Other (Specify) Parkwo  | od Cemetery   | 1 12/30                                       | /2005 Ba   | ltimor              | e, Maryland  |
| - A          | permit. Pages 1 and Department of Heall Important: If Item 2 any Injury or other once.   |                  | 21. Signature of Funeral Service Licensee  Funeral  Funer | 22. Name and Addre                                  | ess of Facility Sch<br>ur Rd., B              | imunek Fu<br>altimore,                           | neral<br>MD 2       | Homes<br>1236  |
|              |  |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart caure. List only one cause on each line.   | ot enter the mode of dyin                           | ng, such as cardiac o                         | r respiratory arrest,                            |                     | Approximate<br>Interval Between  |
|              | Physician  |                  | tmmediate Cause (Final disease or condition resulting in death)  | canc  | el  |  |                     | Onset and Death  (CVS)   |
| 40           | /Medical<br>Examiner   |                  | Due to (or as a consequence of   | of):  |   |  |                     |  |
| 200          |  | ler              | Sequentially list conditions, fary, legating to immediate b. Cualto (or as a consequence of  | si):  |   |  |                     |  |
| اله          | cuted<br>nd<br>ransit  | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events   |   |   |  |                     |  |
| 50,          | cate be executed<br>physicien and<br>the burial-transit  | i Ex             | resulting in death) Last Due to (or as a consequence of  | if):  |   |  |                     | 1  |
| )_(          | phy:   | dicai            | d  |   |   |  |                     |  |
| ox 6         | eath certific<br>ettending p<br>for use as   | an/Me            | IF FEMALE: 23b. Was decedent pregnant 23c. tf yes, outcome of pregnancy  |   |   |  | 23d. Date           | of delivery  |
| J. B.        | death  | ਹ                | in the past 12 months?  1 Yes 2 No Pregnant at time of death   | 3 □Ectopic pregnancy<br>5 □ Other (specify)         | у   |  | Mont                | ,  |
| P.0.         | that the de<br>ed by the detached  | Physi            | 3 CJ OUKUOMA   |   |   |  |                     |  |
| ds,          | Se De o  | ρ                | Part II. Other significant conditions contributing to death but not resulting in   | the underlying cause giv                            | ven in Part I.                                | 1 Yes  | 1.7                 | oute to the cause of death?  |
| SCK<br>Recor | w requir<br>been si<br>should  | Completed        |  |   |   | 24a. Was an                                      | 1                   |  |
|              | The lay  | omo              |  |   |   | autopsy<br>performed                             | f? de               | ere autopsy findings available<br>or to completion of cause of<br>ath? |
| S<br>Vital   |  | e                | 25. Was case referred to medical   |   | 26. Place of Death                            | Check only one                                   | No 1L               | Yes 2 No   |
| of <         | Physician:<br>r this certifice<br>ral director, j  | To B             | examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out   | tpatient 3 DOA Oth                                  | or.   | 7.5  | e 6 Other           | (Specify) NOSPEO   |
| 7 =          | fte<br>on  | ion:             | - Contains   | njury Wor   |   | 28d. Describe how i                              | njury occurred      | 1  |
| Division     | Attending r death.  actor: After by the fune   | ertification:    | 2 Accident investigation 3 Suicide 6 Could not be determined elemined  |   | Yes 2□No                                      | 28f Location (Stree                              | t and Number        | or Rural Route Number.   |
| Div          | after<br>after<br>I Dire<br>d in b   | erti             | 4 Homicide determined building, etc. (Specify)   | m, street, factory, office                          |   | City or Town, S                                  | tate)               | or Harar House Walliber,   |
|              | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the t  | edicai C         | 29a. Certifier (Check only one)  Dertifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.   | Vor invoctingting in my                             | animina dandh anaime                          | and make them to work a distance                 |                     | 4.4 4.41   |
|              | To the within To the comple  | Me               | 29b, Signature and title of certifier  | 29c. Licens   | se number                                     | 29d.   | Date signed (       | Month, Day, Year)  |
|              |  |                  | grand un   | VS  | 8505  | To   | combo               | - 27200-   |
| ふ            | Y  |                  | 30. The and address of person who completed cause of death (Item 23a) (1   | Type, Print)  | 1 11  |  | , , .               | 0  |
|              |  |                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | wares of  | Baltin  | ne me  | 012                 | 04   |
|              | Sta<br>Registr   |                  | 29b Signature and title of certifier  30. mme and address of person who completed cause of death (Item 23a) (1)  ANON CARLS IN THOMAS IN | Sparke  |   |  |                     |  |

|                                |   |                | 1 - For<br>State<br>Registrar  | State of                                       | Maryland / De                                    | epartme<br>Certifica             | nt of H             | lealth ar<br>Death   | nd Mer                |                                    | épe                  | 15                       | 42079  |
|--------------------------------|---|----------------|--|--|--|----------------------------------|---------------------|--|-----------------------|------------------------------------|----------------------|--------------------------|--|
|                                | * 4 : N   |                | Decedent's Name (First, Middle,  | Last)  |  |                                  |                     |  |                       | Date of Death                      |                      |                          | 3. Time of Death                                 |
| 100                            | Physici   |                | Dillys   |  | Eileen   |                                  | Ц                   | enry   |                       | Month                              | Day<br>. 6           | 2005                     | 6.005 M  |
| 10                             | /Medic<br>Examir  |                | 4a. Facility Name (If not institution,   | give street and numb                           |  | 4b. City                         |                     | Location of  |                       | <u> </u>                           | -                    | ty of Death              |  |
| 1                              | Examir  | ıer            |  |  | ·  | 10. 0.0,                         |                     |  |                       |                                    |                      |                          |  |
|                                |   | Section 1      | Cherry Lane I  |  | Age (In yrs. last birtho                         | (av) If Unde                     | Laur<br>er 1 Year   | If Under 24  | 4 Hrs. 8              | Date of Birth                      | PLIII                |                          | George   |
| a.                             | Funeral:<br>Director  |                |  | 1 ☐ M 2[XF                                     | 80 Yrs   | Months                           |                     |  | Min.                  | (Month, Day, 1                     |                      |                          | nplace (State or Foreign<br>untry)               |
| *                              |   |                | 215-76-5263 Usual Residence of Decedent  |  |  |                                  |                     |  | 10                    | 0 13                               | 25                   | Tr                       | inidad   |
|                                | land  |                | 10a. State 10b. County   |  | 10c. City, Town o                                | r Location                       |                     |  |                       | -                                  |                      |                          | 10d. Inside City Limits                          |
|                                | Man,  | ŏ              | MD NA  | ١  | Balti  | more                             |                     |  |                       |                                    |                      |                          | 1X Yes 2 No                                      |
|                                | 158 288   | Director       | 10e. Street and Number   | 3  | Darci  |                                  | p Code              |  |                       | 100                                | g. Citizen o         | f What Cou               | intry?   |
|                                | with a or   | ۵              |  |  |  | 102                              |                     |  |                       | 1                                  |                      |                          | •  |
|                                | e 23  | Funerai        | 4101 Maine A   | 7 E<br>12. Was Decede                          | ent Suprin II C                                  | 12 W D                           | 212                 |  | -2/0                  |                                    |                      | S.A.                     | ican Indian,                                     |
|                                | er de<br>ftem   | S              | 11. Marital Status   | Armed Force                                    | s?   | 13. Was Dece<br>If Yes, sp       | ecify Cuba          | n, Mexican, I  | Puerto Rica           | n, etc.)                           |                      | ace - Amer<br>ack, White |  |
| 36                             | rs af   | by F           | 1 ☐ Never Married 2 ☐ Marrie<br>3 🗓 Widowed 4 ☐ Divorced                           | d 1 ☐ Yes 2s<br>If Yes, Give<br>Year or Date   | ZI 140   | 1 🗆 Yes                          | XXNo                | Specify:   |                       |                                    | Spec                 | ify:                     |  |
| 8                              | hou   |                | 15. Decedent's   |  |  | ecedent's Us                     | ual Ossus           | tion   |                       | 1 44                               | th Kind of           |                          | lack   |
| Ϋ́                             | within 72 hours after death with the Maryland<br>ene.<br>then 'natural', or freme 23a or 28a-f ehow<br>ha Madical Examinar must be notitled at                          | Completed      | (Specify only highest  |  | 10   | ive kind of w                    | ork done o          | furing most o  | of working            | 10                                 | 6b. Kind of          | Business/ii              | ndustry  |
| 7                              | withi<br>then   | Ē              | Elementary/Secondary (0-12)  | College (1-4                                   | or 5+)   |                                  |                     |  |                       |                                    |                      |                          |  |
| 77                             | be filed within 72 hours after death with the Marylan hat Hygiene.  do other then "natural", or fleme 23a or 28a-f ehow event, the Madical Examinat must be notified at |                | 12th grade<br>17. Father's Name (First, Middle, L.                                 | 2yrs   | Pri  | vate                             | Dutz                |  |                       | rst, Middle, Ma                    | Medi                 | cine                     | Aide   |
| an                             | od la de  | Be             |  | ,  |  |                                  |                     | _  |                       |                                    | noon oanne           | 1110)                    |  |
| 2                              | should be<br>and Mental<br>a marked o   | 은              | Cyril King 19a. Informant's Name/Relationshi                                       | - (Time Brief)                                 | 105.04   | latita a Addana                  | - (0)               |  |                       | Jones                              | 0                    | a ~                      |  |
| Baltimore, Maryland 21215-0036 | CA 44 00 00   |                |  | 50   |  |                                  |                     |  |                       | oute Number, (                     |                      |                          | ip Code)   |
| e,                             | 1 and<br>Health<br>em 27<br>ther to   |                | Jennifer Jone 20a. Method of Disposition   | s-Daught                                       | 20b. Place of Di                                 |                                  |                     | Ave,   | Balt<br>Date          | imore                              |                      |                          | 207  |
| ō                              | ges<br>if of l  |                | 1 ☐ Burial 2 【Cremation :  | B Removal from Sta                             | comotoni   | crematory or                     | other place         | e) [   | Date                  | 20                                 | c. Location          | 1 - City or I            | own, State                                       |
| Ë                              | permit. Pages 1 and<br>Depertment of Heali<br>Important: if item 2<br>eny injury or other<br>20028.   |                | 4 □ Donation 5 □ Other (Spe  |  | Metro  |                                  |                     |  | 2/19/                 | /2005                              | Balt                 | 0, M                     | d  |
| 3a                             | Deper<br>Deper<br>Impor<br>Impor<br>Pany in   |                | 21. Signature of Funeral Service Li  | censee   | 211  | 22. Name a<br>March              |                     |  | +                     |                                    |                      |                          |  |
| -                              | 40 5 9 0  |                | Minule   | USTUD  | W  | 4300                             | Waba                | ash A  | ve, I                 | Baltin                             | ore,                 | Md                       | 21215  |
| - 4                            |   |                | 23a. Part . Enter the disease, or c<br>sheck, or heart failure. List o             | omplications that call<br>nly one cause on eac | sed the death. Do not h line.                    | enter the mo                     | de of dying         | g, such as ca  | ardiac or re          | spiratory arres                    | t,                   |                          | Approximate<br>Interval Between                  |
| 100                            | Physician   |                | Inimediate Cause (Final disease or condition                                       | A  | LZHEIT   | MEDS                             | $\sim D$            | EME  | BNT                   | IA                                 |                      |                          | Onset and Death                                  |
|                                | /Medical  |                | resulting in death)  | Due to (or                                     | as a consequence of):                            | ILNO                             |                     | . , , .  |                       |                                    |                      |                          |  |
|                                | Examiner  | 0              |  |  | HYPER  | TE                               | NSI                 | ON   |                       |                                    |                      |                          | SEVERAL  |
|                                | 25  | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or                                     | as a consequence of):                            | ,                                | , - , ,             | - , V  |                       |                                    |                      |                          | YEARS  |
|                                | outed<br>d<br>ansil   | Examiner       | Cause (Disease or injury that initiated events                                     | C  |  |                                  |                     |  |                       |                                    |                      |                          | I EAKS   |
| o Î                            | exection and and rial-tr  | EX             | resulting in death) Last   | Due to (or                                     | as a consequence of):                            |                                  |                     |  |                       |                                    |                      |                          |  |
| 8760,                          | The law requires that the death certificate be executed ale has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit      | dicai          |  | d  |  |                                  |                     |  |                       |                                    |                      |                          |  |
| 89                             | ifical<br>g phy<br>as th  | edi            |  |  |  |                                  |                     |  |                       |                                    |                      |                          |  |
| Вох                            | eath certifi<br>ettending<br>I for use as   | Z              | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome                           |  | _                                |                     |  |                       |                                    | 23d. D               | ate of deliv             | rerv   |
|                                | death<br>e ette<br>d for  | cia            | in the past 12 months?<br>1 □ Yes 2 □ No   |  | 2 ☐ Fetal death<br>t at time of death            | 3 ☐ Ectopic p 5 ☐ Other (s       | pecify)             |  |                       |                                    | M                    | onth                     | Day Year   |
| P.O.                           | that the de<br>ad by the<br>detached  | Physician/Me   | 9 Unknown  | 9□ Unknow                                      | 1  |                                  |                     |  |                       |                                    |                      |                          |  |
|                                | res that<br>igned to<br>be deta   |                | Part II. Other significant condition   | s contributing to deat                         | h but not resulting in th                        | e underlying                     | cause give          | n in Part I.   |                       | 23e. Did toba                      | cco use cor          | ntribute to              | the cause of death?                              |
| g,                             | uires<br>sigr<br>ld be  | d by           | POST T   | 4ROMB.   | OTIC S   | YND                              | ROI                 | ME   |                       | 1 🗌 Yes                            | 2 <b>N</b> O         | 3 Pro                    | bably 4 Unknown                                  |
| Ö                              | w requir<br>been si<br>should   | Completed      |  |  |  |                                  |                     |  |                       | 04- 146                            | - 1                  | 144                      | 0-45-  |
| He He                          | has<br>has  | E              |  |  |  |                                  |                     |  |                       | 24a. Was an<br>autopsy<br>performs |                      | prior to co<br>death?    | opsy findings available<br>ompletion of cause of |
| <u></u>                        |   |                |  |  |  |                                  |                     |  |                       |                                    | Ø'No                 | 1 ☐ Yes                  | 2 No   |
| ij                             | ician: Th<br>certificete<br>rector, pag   | Be             | 25. Was case referred to medical examiner?   | t Inneite t                                    |  |                                  | Tex                 |  | f Death (Cf           | neck only one                      |                      |                          |  |
| 7                              | this aldir  | မ              | 1 ☐ Yes 2 No   |  | atient 2 ER/Outpa                                |                                  |                     | 4 Nursi  | ing Home              | 5 Residen                          | ce 6 □Ot             | ther (Speci              | fy)  |
| Ē                              | Ing F   | Ö              | 27. Manner of Death  1 Natural 5 Pending   | 28a. Date of I<br>(Month,                      | njury 28b. Tim<br>Day Year) 1nju                 | ry                               | 28c. Injury<br>Work | at<br>?  | 28d.                  | Describe how                       | injury occu          | ırred                    |  |
| sio                            | death<br>ctor: /  | cati           | 2 Accident investiga 3 Suicide 6 Could no  |  |  | М                                | 1 🗆 Y               | /es 2 □ No   | 2                     |                                    |                      |                          |  |
| Division of Vital Records,     | after d<br>Direct<br>Direct<br>I in by  | Certification: | 4 Homicide determin  | ed 289. Place of                               | Injury - At home, farm, etc. (Specify)           | , street, factor                 | ry, office          |  | 28f.                  | Location (Stre<br>City or Town, .  | et and Num<br>State) | ber or Rur               | al Route Number,                                 |
|                                | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical complaint filled in by the funeral director,        |                | S.F.   |  |  | - 31/35                          |                     |  |                       |                                    |                      |                          |  |
|                                | Hosp<br>4 hours<br>Funs<br>ely fi   | edicai         | (Check only 2 Medical E  | caminer: On the basi                           | st of my knowled je. d<br>s of examination and/o | eath occurred<br>r investigation | d at the tim        | e, date and printed and printe | place, and occurred a | due to the cau                     | se(s) and m          | and due t                | o the cause(s)                                   |
|                                | To the Hospital within 24 hours a To the Funeral Completely filled  | Med            | 0110)  | and manner                                     | stated.  |                                  |                     |  |                       |                                    |                      |                          |  |
| <b>\</b>                       | N T CO  | -              | 29b. Signature and title of certifier  | Veryeen  | V 11 5   | 29                               | c. License          |  | 0,14                  |                                    |                      |                          | Day, Year)                                       |
|                                |   |                | + Hugh   | A  | 1010   |                                  | <u>_</u>            | 212  | 17                    |                                    | 12/                  | 2+1                      | 12005  |
|                                | 3   |                | 30. Name and address of person w   | no complet cause of                            | of death (Item 23a) (Ty                          | pe, Print)                       | 105 -               | 0 45   |                       |                                    | 1 1 -                |                          | 1>0-1-   |
|                                |   |                | ABDUL NAYEEM M.D. 3450 FORT MEADEROAD SUITE 100, LAUREL,                           |  |  |                                  |                     |  |                       |                                    |                      |                          |  |
| 73                             | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  DF C. 2. 9 2005                                 | 32, Reg  | strar's Gignature                                | W.                               |                     | ,  |                       |                                    |                      |                          |  |

|                     |  | •                             | For State Registrar   | State of N   | <b>1</b> arylan                |   | artment<br>rtificate                    |                                    |                                      |                            |                                     | giene                    | Hin  | 420                      | 80                           |
|---------------------|--|-------------------------------|---|--|--------------------------------|---|---|------------------------------------|--------------------------------------|----------------------------|-------------------------------------|--------------------------|--|--------------------------|------------------------------|
|                     | Physici  | an                            | Decedent's Name (First, Middle, Las   | ) , ; ,  |                                |   |   |                                    |                                      |                            | 2. Date of De<br>Month<br>Decemb    | ath<br>Day               | 2, 2005  |                          | e of Death                   |
|                     | /Medic   | al                            | 4a. Facility Name (If not institution, give   | olland   | r)                             |   | 4h Cih                                  | Town or                            | Location of                          |                            | Decemb                              | _                        | County of Dea                                    |                          | 0 AM M                       |
|                     | Examin   | ier                           | 29 W. Washington  |  | ()                             |   | 40. City,                               |                                    | nnap                                 |                            |                                     |                          | ne Aru   |                          |                              |
|                     | Funeral  |                               | Social Security Number 6. S | x . 7. A   |                                | last birthday)                            | If Under                                | 1 Year                             | If Under                             | 24 Hrs.                    | 8. Date of Bir                      | th                       | 9 Bi   | tholace (Sta             | ate or Foreign               |
|                     | Director   |                               | 218-32-9026   | □M 2 <b>/</b> 0 F  |                                | 71 Yrs.                                   | Months                                  | Days                               | Hours                                | Min.                       | Jan 7,                              | 193                      | 4 Mar  | yland                    |                              |
|                     | and **   |                               | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. Cit                       | y, Town or Lo                             | cation                                  |                                    |                                      |                            |                                     |                          |  | 10d Insid                | e City Limits                |
|                     | Maryl.   | io                            | MD Anne Aru   | ındel  |                                | apolis                                    |   |                                    |                                      |                            |                                     |                          |  |                          | Yes 2 □ No                   |
|                     | r 28a  | rec                           | 10e. Street and Number  |  |                                | 1   | 10f. Zip                                | Code                               |                                      |                            | -                                   | 10g. Citi                | zen of What C                                    | ountry?                  |                              |
|                     | th with  | al D                          | 29 W. Washington  | Street   |                                |   | 214                                     | 01                                 |                                      |                            |                                     | Unit                     | ed Sta   | tes                      |                              |
| 920                 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f ehow other treumatic event, the Medical Examinal must be notified at | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Deceder<br>Armed Forces<br>1 Tyes 2 M<br>If Yes, Give 7<br>Year or Dates | ?<br><b>(</b> No               |   | Was Deced<br>f Yes, spec<br>1 Yes 2     |                                    | spanic Ori<br>n, Mexican<br>Specify: |                            | ify Yes or No<br>lican, etc.)       | )-                       | 14. Race - Am<br>Black, Whi<br>Specify:<br>BLack |                          | n,                           |
| Maryland 21215-0036 | within 72 ho<br>ene.<br>then "natur<br>he Medical  | ompieted                      | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)  |  | r 5+)                          | 16a. Dece<br>(Give<br>life.<br>Nurse      | dent's Usua<br>kind of wor<br>DO NOT us | l Occupa<br>k done d<br>e retired) | tion<br><i>uring m</i> os            | t of working               | g                                   | 1                        | nd of Business<br>te Gove                        |                          | t                            |
| land 2              | should be filed withind Mental Hygiene.  marked other ther umatic event, the   | To Be Co                      | 17. Father's Name (First, Middle, Last) Henry Collins   |  |                                | <u> </u>                                  |   |                                    |                                      | er's Name<br>phine         | (First, Middle,                     |                          | Sumame)  |                          |                              |
|                     | and 2 sho<br>ealth and h<br>n 27 Is me   | ľ                             | 19a. Informant's Name/Relationship (7) Thomas Holland /   |  |                                | 1   | -                                       |                                    |                                      |                            |                                     |                          | r Town, State,<br>, MD 2                         |                          |                              |
| Baltimore,          | Page<br>nent c<br>ant: If<br>ury or  |                               | 20a. Method of Disposition  1 Burial 2 Cremation 3 1  4 Donation 5 Other (Specify,  |  | e c                            | Place of Dispo<br>emetery, crea<br>ews Me | natory or ot                            | her place                          | . }                                  |                            | ec 28                               |                          | cation - City or                                 |                          | Э                            |
| Balt                | permit. Pag<br>Department<br>Importent: I<br>any Injury o  |                               | 21. Signature of Puny all Service Licen   | s of Facilit<br>Metro<br>st Dr   | polit<br>ive                   | tan Cha<br>Annapa                         | apel<br>olis,                           | , MD                               |                                      |                            |                                     |                          |  |                          |                              |
|                     | Physician<br>/Medical<br>Examiner  | ner                           | 23a. Part 1. Enther the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury   |  |                                | legoun                                    | Approxii<br>Interval<br>Onset a         | mate Between and Death CCUS        |                                      |                            |                                     |                          |  |                          |                              |
| ox 68760,           | The law requires that the death certificate be executed to hes been signed by the attending physician and hage 2 should be detached for use as the burial-transit  | n/Medical Examiner            | resulting in death) Last  | Due to (or a d   | e of pregna                    | incy                                      |   |                                    |                                      |                            |                                     |                          | 23d. Date of de                                  | livery                   |                              |
| O. B                | it the death<br>by the atte<br>tached for  | Physician/Me                  | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1□Live birth<br>4□Pregnant<br>9□ Unknown   |                                |   | Ectopic pre<br>Other (spe               |                                    |                                      |                            |                                     |                          | Month  | Day                      | Year                         |
| Records, P.         | w requires that<br>been signed<br>should be det  | by                            | Part II. Other significant conditions co  | ntributing to death  | but not resi                   | ulting in the u                           | nderlying ca                            | iuse give                          | n in Part I.                         |                            | 23e. Did t                          |                          | se contribute t                                  |                          | of death?                    |
|                     |  | Completed                     |   |  |                                |   | _                                       |                                    |                                      | -                          | 24a. Was<br>autor<br>perfo<br>1 Yes | an<br>osy<br>ormed?      | 24b. Were a prior to death?                      | completion               | ngs available<br>of cause of |
| Vital               |  | o Be                          | 25. Was case referred to medical examiner?  | Hospital:  | siant O 🗆                      | FB(0                                      |   | Othe                               | r                                    |                            | Check on c                          |                          |  |                          |                              |
| ion of              | Attending Phyer death. sector: After this by the funeral di  |                               | 27. Manner of Death  1 Matural 5 Pending 2 Accident investigation   | 1 ☐ Inpa<br>28a. Date of In<br>(Month, E   | jury                           | ER/Outpatier<br>28b. Time of<br>Injury    |   | Bc. Injury<br>Work                 | at                                   |                            | e by Hesia<br>3d. Describe I        |                          | S □Other (Spe<br>y occurred                      | icity)                   |                              |
| Division            | lef or Atte<br>s after de<br>el Directo<br>ed in by th   | Certification;                | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of I<br>building,   | njury - At ho<br>etc. (Specify | ome, farm, str                            | eet, factory,                           | , office                           |                                      | 28                         | 3f. Location (:<br>City or Tox      | Street and<br>vn, State) | d Number or R<br>)                               | ural Route N             | lumber,                      |
|                     | To the Hospitel or Attending Ph<br>within 24 hours atter death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  | Medical                       | 29a. Certifier (Check only one) Check only 2 Medical Exam   | sicien: To the besiner: On the basis and manner:                                 | of examina                     | wledge, deatl<br>tion and/or in           | occurred a<br>vestigation,              | it the time<br>in my op            | e, date an<br>inion, dea             | d place, an<br>th occurred | nd due to the<br>d at the time,     | cause(s)<br>date and     | and manner a<br>place, and due                   | s stated.<br>to the caus | se(s)                        |
| )                   | To the within 2 To the complet   | Σ                             | 29b. Signature and title of certifier   | Mes  | 14                             | Mo  |   | License<br>D 4/                    |                                      | 36                         |                                     |                          | e signed (Moni                                   |                          |                              |
| _                   | φ  |                               | 30. Name and address of person who co<br>Sharon M. M.   | 1-15   | death (Item                    | 23a) (Type,                               | Print)                                  | Pira                               | c Ra                                 | , RI                       | napo                                | 15                       | 1270   | 2140                     | 5/                           |
|                     | Sta<br>Registr   |                               | 31. Date filed (Month, Pay, Year) DEC 2 9 2005  | 22. Regis  | trar's Signa                   | ture                                      |   |                                    | 7                                    |                            |                                     |                          |  |                          |                              |

|                     |  |                   | For Stata Registrar  | ate of Marylan   |                                    | rtment of H  |  |   | iene 05   | 2081                                   |  |  |  |
|---------------------|--|-------------------|--|--|------------------------------------|--|--|---|---|--|--|--|--|
|                     | Physici<br>/Medic  |                   | Decedent's Name (First, Middle, Last)  | Evelyn E.  | Heiland                            | 1  |  | 2. Date of Dea<br>Month<br>Decembe            | Day Year  | 3. Time of Death                       |  |  |  |
|                     | Examin   | er                | 4a. Facility Name (If not institution, give stree  Keswick MultiCare Ce  5. Social Security Number 6. Sex  |  | last hirthday)                     | 4b. City, Town, or Ba1   | timore   |   | 4c. County of Death                             | n<br>uplace (State or Foreign          |  |  |  |
|                     | Funeral<br>Director  |                   | 212-28-5871 1 M Usual Residence of Decedent  | 2 x F 9  | 5 Yrs.                             | Months Days  | Hours Min.   | 8. Date of Birth<br>(Month, Day<br>March 2    | 9, 1910 Ma                                      | aryland                                |  |  |  |
|                     | he Marylar<br>8a-f show<br>otified at  | Director          | Maryland N/A   | 10c. Cit   | y, Town or Loc<br>Bal              | Ltimore  |  |   |   | 10d. Inside City Limits 1 □ Yes 2 □ No |  |  |  |
|                     | 23a or 2   |                   | 10e. Street and Number Keswick MultiCare 7   | 00 W. 40th   | Street                             | 10f. Zip Code  | 212  |   | 0g. Citizen of What Co.                         | JSA                                    |  |  |  |
| 920                 | be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "neturel", or Items 23a or 28a-f show event, the Mydral Exam har mutter notified at | by Funeral        | 1 Never Married 2 Married  | Vas Decedent Ever in U<br>trmed Forces?<br>☐ Yes 2 <b>[]X</b> lo<br>i Yes, Give<br>'ear or Dates:  | lf .                               | /as Decedent of His<br>Yes, specify Cubar<br>☐ Yes 2001/No                 | spanic Origin? (S<br>n, Mexican, Puert<br>Specify: | pecify Yes or No-<br>to Rican, etc.)          | 14. Race - Amer<br>Black, White<br>Specify: W   |  |  |  |  |
| Maryland 21215-0036 | filed within 72 he<br>Hygiene.<br>Ither than "netur<br>ant, Ihr Wedical  | Completed         | 15. Decedent's Educatic<br>(Specify only highest grade con<br>Elementary/Secondary (0-12)  | n<br>mpleted)<br>College (1-4or 5+)  | (Give k                            | ent's Usual Occupa<br>cind of work done d<br>O NOT use retired,<br>Homemak | uring most of wor                                  | rking   | 16b. Kind of Business/I                         |  |  |  |  |
| yland 2             |  | To Be Co          | 17. Father's Name (First, Middle, Last) Samuel Enterline Ste   | ffey   |                                    |  | 18. Mother's Nar                                   | me (First, Middle, I<br>Lla Robin             | Maiden Sumame)                                  | 1 Home                                 |  |  |  |
| Mar                 | nd 2 shu<br>lith and<br>27 is m<br>r treum   |                   | 19a. Informant's Name/Relationship (Type, Information Name) Pamela Nichols Da  | <sub>rint)</sub><br>ughter   |                                    | Roland A   |  |   | e, City or Town, State, Z<br>e, Maryland        |  |  |  |  |
| Baltimore,          | f H  |                   | 20a. Method of Disposition  1XXBurial 2 □ Cremation 3 □ Remo  14 □ Donation 5 □ Other (Specify)  | 20b. F   | Place of Dispos                    | ition (Name of atory or other place  | 9)   | Date  | 20c. Location - City or 1 Sykesvill             | own, State                             |  |  |  |
| Balt                | permit. Page<br>Department of<br>Importent: If<br>any injury or<br>once.   |                   | 21. Signature of Funeral Service Licensee  | Saltimore  | Home, Inc.                         |  |  |   |   |  |  |  |  |
|                     | Physician<br>/Medical  |                   | 23a. Rant. Enter the disease, or complication shock, or heart favore. List only one call immediate Cause (Final disease or condition resulting in death)   | or respiratory arr   |                                    | Approximate<br>Interval Between<br>Onset and Death<br>YEARS                |  |   |   |  |  |  |  |
|                     | Examiner   | ler               | Sequentially list conditions, if any, leading to immediate   | Due to (or as a consequence of the consequence of t |                                    |  |  |   |   |  |  |  |  |
| ,8760,              | te be executed<br>ysician and<br>e burial-transit  | ai Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a conseq   | uence of):                         |  |  |   |   |  |  |  |  |
| .O. Box 687         | The law requires that the death certificate be executed tite has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit   | Physician/Medicai | in the past 12 months?   | f yes, outcome of pregna<br>□ Live birth 2 □ Feta<br>□ Pregnant at time of c<br>□ Unknown  | Ideath 3                           | Ectopic pregnancy<br>Other (specify)                                       |  |   | 23d. Date of delin                              | very<br>Day Year                       |  |  |  |
| α.                  | w requires that<br>been signed by<br>should be deta  | by                | Part II. Other significant conditions contrib  | iting to death but not res   | ulting in the un                   | derlying cause give  | n in Part I.                                       | 23e. Did tol                                  | bacco use contribute to<br>es 2 ☑No 3 ☐ Pro     | the cause of death?                    |  |  |  |
| al Records,         |  | Completed         |  |  |                                    | 24a. Was a autops perform  | med? prior to condeath?                            | opsy findings available ompletion of cause of |   |  |  |  |  |
| f Vital             | Physician: The this certificate all director, pages  | То Ве             | 25. Was case referred to medical examiner? 1 Yes 2 No Hosp   | ital: 1   Inpatient 2  |                                    | ath (Check only on<br>lome 5 Reside  | e)<br>ence 6 Other (Spec                           | ify)  |   |  |  |  |  |
| Division of         | tending Ph<br>leath.<br>tor: After th<br>the funeral   |                   | 27. Manper of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred |  |                                    |  |  |   |   |  |  |  |  |
| Div                 | ital or Al   | Certif            | 4 Homicide determined  | Be. Place of Injury - At n<br>building, etc. (Specia   | ome, tarm, stre                    | et, factory, office  |  | City or Town                                  | reet and Number or Rui<br>n, State)             | al Route Number,                       |  |  |  |
|                     | To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | Medical           | 29a. Certifier 1 Certifying Physicia (Check only one) 1 Medical Examiner:  | n: To the best of my kno<br>On the basis of examina<br>and manner stated.  | owiedge, death<br>ation and/or inv | estigation, in my op   | inion, death occu                                  | a, and due to the carred at the time, d       | ause(s) and manner as<br>ate and place, and due | stated,<br>to the cause(s)             |  |  |  |
|                     | with To  | 2                 | 29b. Signature and title of certifier  Malelle Maa   | greger   | MD                                 | 29c. License   | number<br>657                                      | ~   | 9d. Date signed (Month<br>) ecember 2           |  |  |  |  |
|                     | 6  |                   | 30. Name and address of person who compl<br>The Brute They   | eted cause of death (Iter  | n 23a) (Type, F                    | Print)<br>+0 46 57   | REET, B  | BALTIOTA                                      | RE, 170 2                                       | 211                                    |  |  |  |
|                     | Sta<br>Registi   |                   | 31. Date filed (Month, Day, Year) DEC 2 9 2005   | 32. Registrar's Signa  |                                    |  |  |   |   |  |  |  |  |

|                 |  |                  | 1 - For<br>State<br>Registrar  | State of Maryland / E  | Department of F<br>Certificate of a              |   |  | eg:No.005                                       | 42082                                |
|-----------------|--|------------------|--|--|--|---|--|---|--------------------------------------|
| Г               | Dhysisi  |                  | 1. Decedent's Name (First, Middle, Last)   |  |  |   | 2. Date of Dea<br>Month                | th<br>Day Year                                  | 3. Time of Death                     |
|                 | Physicia<br>/Medic   |                  |  | Agnes Gail Holde   | <u>r</u>   |   |  | er 27, 200                                      | 5 9:26 A M                           |
|                 | Examin   |                  | 4a. Facility Name (If not institution, give s                                      | treet and number)  | 4b. City, Town, o                                | r Location of Death                         |  | 4c. County of Dea                               | th                                   |
|                 |  |                  |  | oan Hospital   |  | Bethesda<br>If Under 24 Hrs.                | T                                      |   | tgomery                              |
|                 | Funeral<br>Director  |                  | 5. Social Security Number 6. Sex   | M 2XF  | thday) If Under 1 Year Months Days               | Hours Min.                                  | 8. Date of Birth<br>(Month, Day        | , Year) Co                                      | thplace (State or Foreign<br>buntry) |
|                 |  |                  | 215-36-2889 Usual Residence of Decedent  | 67   |  |   | August 1                               | 1, 1938 Was                                     | hington, D.C.                        |
|                 | ylanch how   |                  | 10a. State 10b. County   | 10c. City, Town  | or Location                                      |   |  |   | 10d. Inside City Limits              |
|                 | e Ma   | cto              | Maryland Monte   | omery  | В  | ethesda                                     |  |   | 1 ☐ Yes 2 X No                       |
|                 | or 28  | Funeral Director | 10e. Street and Number   |  | 10f. Zip Code                                    |   |  | 0g. Citizen of What Co                          | ountry?                              |
|                 | eth w  | œ.               |  | Mill Road  |  | 20817                                       |  | Unite   | d States                             |
|                 | er de<br>Itsm  | une              |  | 2. Was Decedent Ever in U.S.<br>Armed Forces?  | 13. Was Decedent of H<br>If Yes, specify Cuba    | lispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)       | 14. Race - Ame<br>Black, Whit                   |                                      |
| 2               | rs aft   | by F             | 1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced                             | 1 ☐ Yes 2 ሺ No<br>If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 🗓 No                                   | Specify:                                    |  | Specify:  |                                      |
| 5               | 2 hou  |                  | 15. Decedent's Educ  | ation 16a.   | Decedent's Usual Dccup                           | ation                                       |  | 16b. Kind of Business                           | White                                |
| 3               | hin 7  | Completed        | (Specify only highest grade  | College (1-4or 5+)   | (Give kind of work done life. DO NOT use retired | during most of world)                       | king                                   | Montgome  | ry County                            |
| 1               | giene<br>er th   | 5                |  | 2  | Events Co  | ordinato                                    | <u> </u>                               |   | Education                            |
| 2               | 2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or itsma 23a or 28a-f show sumatic event, the Medical Examiner must be notified at   | Be (             | 17. Father's Name (First, Middle, Last)  |  |  | 18. Mother's Nam                            | e (First, Middle,                      | Maiden Surname)                                 |                                      |
| 7               | Men Men arke   | ပ္               |  | l Edward Peake   |  |   | Agnes L                                | avone Grov                                      | e                                    |
|                 | ges 1 end 2 should be filed within 72 hours after deeth with the Marylan it of Heelth and Mental Hygiene. If Item 27 is marked other than "natural", or itsms 23s or 28s-f show or other traumatic event, Its Medical Examiner must be notified at |                  | 19a. Informant's Name/Relationship (Typ  | pe, Print) 19b   | . Mailing Address (Street                        |   |  |   |                                      |
| ב<br>ט          | 1 end<br>Heelth<br>iem 27<br>other tr  |                  | Deborah Susan Metz<br>20a. Method of Disposition                                   |  | 7618 Bells Disposition (Name of                  |   | d Bethes                               | da, Maryla<br>20c. Location - City or           |                                      |
| 5               | permit. Pages 1 en<br>Depertment of Heel<br>Important: if Item 2<br>eny injury or other<br>once.   |                  | 1 XBurial 2 ☐ Cremation 3 ☐ Re   | emoval from State  | y, crematory of other place.                     | ce)   | nuary                                  | 20c. Location - City or                         | Town, State                          |
|                 | permit. Pa<br>Depertmen<br>mportant<br>any injury  |                  | 4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License           |  | on Cemetery                                      | 4,  | 2006                                   | Rockville                                       | . Maryland<br>uneral Home/           |
| 0               | permit. Depertumpent imports sny injustrations.  |                  | 21. Signature of Therain Service Electrise   | - / 1  | Bethesda-C                                       | Chevy Cha                                   | se, Inc.                               | 7557 Wisc                                       | onsin Avenue                         |
|                 |  | $\dashv$         | 23a. Part 1. Enter the disease, or complic   | eations that caused the death. Do  | Bethesda,  | Maryland og. such as cardiac                | 20814-3                                | 501<br>est.                                     | Approximate                          |
|                 | Physician  |                  | snock, or heart failure. List only on<br>Immediate Cause (Final                    | e cause on each line.  |  |   |  |   | Interval Between<br>Onset and Death  |
|                 | /Medical   |                  | disease or condition resulting in death)   | Psuedomas Pne  Due to (or as a consequence   |  |   |  |   |                                      |
|                 | Examiner   |                  | 0  |  |  |   |  |   |                                      |
|                 | n ==   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence  | of):   |   |  |   |                                      |
|                 | erute<br>ind<br>trans  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last            |  |  |   |  |   |                                      |
|                 | cate be executed<br>physicien and<br>the burial-transit  | 9                | resulting in death) cast   | Due to (or as a consequence  | of):   |   |  |   |                                      |
| 0               | physic the b   | dicai            | <b>Q</b> d   |  |  |   |  |   |                                      |
| ٥<br>۲          | w requires thet the death certific<br>been signed by the ettending p<br>should be detached for use as  | Physician/Me     | IF FEMALE:   | 3c. If yes, outcome of pregnancy   |  |   |  |   |                                      |
| מ               | etten<br>etten<br>I for u  | clan             | in the past 12 months?   | 1 Live birth 2 ☐ Fetal death 4 Pregnant at time of death                                       | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)        | ,   |  | 23d. Date of dei<br>Month                       | Day Year                             |
| į               | by the   | iysi             | 1 □ Yes 2 🔯 No<br>9 □ Unknown  | 9☐ Unknown   | o Z o mor (apochy) _                             |   |  |   |                                      |
| 7               | s thet   | by PI            | Part II. Other significant conditions con  | tributing to death but not resulting in  | the underlying cause giv                         | en in Part I.                               | 23e. Did to                            | bacco use contribute to                         | the cause of death?                  |
| 20.000          | quire<br>an sig<br>uld b   |                  | Coronary 0   | bstructive Pulmo   | nary Disease                                     | e   | 1 🗆 Y                                  | es 2□No 3□Pr                                    | obably 4 Munknown                    |
| ֚֭֚֝֝֝֟֝֝֝֟֝֝֟֝ | aw re  | piet             |  |  |  |   | 24a. Was a                             |   | utopsy findings available            |
|                 | sician: The law is certificate has built inector, page 2 sh  | Completed        |  |  |  |   | autops<br>perfor                       | med?   death?                                   | completion of cause of               |
| A II CO         | ysician: The<br>is certificete hi<br>director, pege  | BeC              | 25. Was case referred to medical examiner?   |  |  | 26. Place of Deal                           |  |   | 20110                                |
|                 | > 20   | 2                | 1 ☐ Yes 2 ☒ No   | ospital:<br>1∭Inpatient 2☐ER/Ou  | tpatient 3 DOA Oth                               | er: 4 Nursing Ho                            | me 5 Reside                            | ence 6 Other (Spe                               | cify)                                |
| =               | 5 E S  |                  | 27. Manner of Death 1 X Natural 5 ☐ Pending  |  | rime of 28c. Injur                               | y at<br>k?                                  | 28d. Describe hi                       | ow injury occurred                              |                                      |
| 2               | Attending<br>ir deeth.<br>ector: After<br>by the fune  | cati             | 2 Accident investigation 3 Suicide 6 Could not be                                  |  |  | Yes 2 □ No                                  |  |   |                                      |
|                 | spitel or Attending Phous after deeth. hers! Director: After th  | ertification;    | 4 Homicide determined  | 28e. Place of Injury - At home, fa<br>building, etc. (Specify)                                 | rm, street, factory, office                      |   | 28f. Location (Si<br>City or Town      | reet and Number or Ru<br>n, State)              | ural Route Number,                   |
|                 | pitei<br>ours a<br>erst I  | O                | 29a. Certifier 1 ☐ Cartifying Phys   | inians. To the heat of my keepyledes   | dans.  |   |  |   | •                                    |
|                 | To the Hospitel or Attendi<br>within 24 hours after deeth.<br>To the Funeral Director: A<br>completely filled in by the fu   | edicai           | (Check only one)   | ician: To the best of my knowledge<br>ar: On the basis of examination an<br>and manner stated. | d/or investigation, in my o                      | ne, date and place,<br>pinion, death occur  | and due to the c<br>red at the time, d | ause(s) and manner as<br>ate and place, and due | s stated.<br>to the cause(s)         |
|                 | To the Hos<br>within 24 h<br>To the Fur<br>completely  | Me               | 29b. Signature and little of certifier   |  | 29c. Licens                                      | e number                                    | 2                                      | 9d. Date signed (Mont                           | h, Day, Year)                        |
|                 | - > - 0  |                  | b little   |  | 700613   | 07_   |  |   |                                      |
|                 | 10   |                  | 30. Name and address of person who co  | repleted cause of death (Item 23a)   |  |   |  | December  | 28, 2005                             |
|                 | 1  |                  | Atul Rohatgi, M.D.   | 8600 Old George  |  | thesda.                                     | Marvland                               | 20814   |                                      |
|                 | Sta  |                  | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signature   |  |   |  |   |                                      |
|                 | Registr  | ar               | DFC 2 9 2005   | Keneus &   | WOL.   |   |  |   |                                      |

|  |                      | 1 - State<br>Registrar  | Maryland  |                                      | rtment<br>tificate                         |                            |                         | ind M                 |   | giene<br>Reg. No.     | 05                       | 42083   |
|--|----------------------|---|---|--------------------------------------|--|----------------------------|-------------------------|-----------------------|---|-----------------------|--------------------------|---|
| Physic<br>/Medi  | cal                  | 1. Decedent's Name (First, Middle, Last)  INA W. HOLLAND  |   |                                      |  |                            |                         |                       | 2. Date of De<br>Month                      | Day<br>25             | 200                      | 5 1:30 AM   |
| Examir   |                      | 4a. Facility Name (If not institution, give street and num 23 SILOPANNA RD.   |   |                                      | 4b. City, T<br>ANNAP                       | OLIS                       | 5                       |                       |   | Aì                    | County of D              | UNDEL   |
| Funeral<br>Director  |                      | 5. Social Security Number  219–26–4424  Usual Residence of Decedent   | 7. Age (In yrs. las   | Yrs.                                 | If Under 1<br>Months                       | Days                       | Hours                   | Min.                  | 8. Date of Bir<br>(Month, Da<br>7-8-194     | y, Year)<br>+0        | MA                       | Birthplace (State or Foreign<br>Country)<br>RYLAND                  |
| Maryland<br>a-f show   | tor                  | 10a. State 10b. County MD • ANNE ARUNDEL  | 1   | Town or Loc                          |  | -                          |                         |                       |   |                       |                          | 10d. Inside City Limits 1 XYes 2 No                                 |
| h with the   | Funeral Director     | 10e. Street and Number 23 SILOPANNA RD.   |   |                                      | 10f. Zip C                                 | ode<br>403                 |                         |                       |   | 10g. Citiz            | zen of What              | Country?  |
| 2 should be filed within 72 hours after death with the Maryland 2 should be filed within 72 hours after death with the Maryland Is marked other than "natural", or Itams 23a or 28a-f show aumatic avant. It a Madical Exacultation out to motified at   | þ                    |   | 2 TXNo  |                                      |  | nt of His<br>y Cubar       | spanic Origin, Mexican, | gin? (Spe<br>, Puerto | ecify Yes or No<br>Rican, etc.)             | -                     | 14. Race - A<br>Black, W | mencan Indian,<br>hite, etc.<br>BLACK                               |
| ithin 72 ho<br>ne.<br>nan "natur<br>Madical  | Completed            | 15, Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-   |   | (Give i                              | lent's Usual<br>kind of work<br>OO NOT use | done di                    | urina most              | of worki              | ng  | 16b. Kir              | nd of Busine             | ss/Industry   |
| uld be filed with the filed with the filed with the filed with the file avant, the file avant, the files with t | To Be Con            | -124-  17. Father's Name (First, Middle, Last)  JAMES E. WOMACK, SR.  |   | AIRTE                                | RAFFIC                                     | -                          | 18. Mother              | r's Name              | (First, Middle,                             | Maiden                |                          | VIATION ADMIN   |
| and 2 shouealth and Mm 27 Is mai   |                      | 19a. Informant's Name/Relationship (Type, Print) KEVIN D. HOLLAND(SON)  |   |                                      |  |                            |                         |                       | ILVER S                                     |                       |                          | e, Zip Code)<br>• 20902   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Protection 1 files 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event. If a Marical Examinational Lorrottilled at once.  |                      | 20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from S  4 □ Donation 5 □ Other (Specify)  21. Signature of Furieral Service Licensed HARRY | BESTO   | netery, crem<br>GATE N               |  | AL I                       | PARK                    | 12-3                  |   | ANNA                  | APOLIS                   | or Town, State , MARYLAND RTUARY, P.A.                              |
| Physician<br>/Medical<br>Examiner  | Examiner             | Sequentially list conditions, if any, leading to immediate cases. Enta. Underlying Cause (Disease or injury that initiated events                           |   | heor                                 |  | of dying                   | , such as               |                       | LIS, Mi                                     |                       | AND 21                   | Approximate Interval Batwaen Onset and Death                        |
| The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/Medical Ex | d   | or as a consequent come of pregnance the 2 Fetal death at time of death with the control of the | eath 3□                              | Ectopic pred                               |                            |                         |                       |   | 2                     | 3d. Date of o            | delivery<br>Day Year  |
| uires that the d   | by                   | Part II. Other significant conditions contributing to de  | ath but not resulti   | ing in the un                        | iderlying cau                              | use give                   | n in Part I.            |                       | 23e. Did to                                 |                       |                          | to the cause of death?  Probably 4 Unknown                          |
| ician: The law requi<br>certificate has been s<br>ector, page 2 should   | Completed            |   |   |                                      |  |                            |                         |                       | 24a. Was<br>autor<br>perfo<br>1 🗆 Yes       |                       | prior t<br>death         | autopsy findings available o completion of cause of ? es 2 \( \) No |
| ng Phys<br>fter this   | ertification: To Be  | 27. Manner of D ath 1 XVatural 5 Pending (Mont) 2 Accident investigation  | f Injury 28<br>o, Day Year)   | NOutpatient<br>8b. Time of<br>Injury | 286<br>M                                   | Other c. Injury Work' 1  Y | . 4 🗆 Nur               | sing Hor              | (Check only on the Residue 128d. Describe I | dence 6<br>now injury | occurred /               |   |
| To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funaral Director: A<br>completely filled in by the tu   | O                    | 4 Homicide determined 288. Place buildin  | of Injury - At home<br>g, etc. (Specify)<br>best of my knowle   | edge, death                          | occurred at                                | the time                   | a, date and             | d place, a            | City or Tov                                 | vn, State)            | and manner               | Rural Route Number,   |
| To the Hospital or within 24 hours aft to the Funaral Dit completely filled in   | Medical              | one) 2 Medical Examiner: On the ba  | sis of examination<br>er stated.  | n and/or inv                         | restigation, is                            | n my opi                   | nion, deat              | h occurre             | ed at the time,                             | date and              | place, and d             | ue to the cause(s)  |
| 4  | ate                  | 30. Name and address of erson who completed cause Division of ENDOCRINOZOGY/H  31. Date filed (Month, Day, Year)  | of death (Item 2:<br>ETABULSH<br>egistrar's Signatur  | (Type, I                             | Print)<br>US HOPK                          | ins V                      | Wir Sa                  | ch He                 | of Smite                                    | 383                   | 1830                     | E Monument 8.   |

CPM 05-7830 Kenneth Jones

|   |   |                |   | Item 21 per   | FH, G850, 12                               | 29/05/16/  | Death  |  | 2005<br>g. No.                | 42085  |
|---|---|----------------|---|---|--|--|--|--|-------------------------------|--|
|   | Physici   |                | 1. Decedent's Name (First, Midd<br>Kenneth  | lle, Last)<br><b>Jones</b>  |  |  |  | 2. Date of Death<br>Month<br>November      | Day Year 200                  | 3. Time of Death 5 10:33 A <sup>M</sup>          |
|   | /Medic<br>Examir  |                | 4a. Facility Name (If not institution   |   |  | 4b. City, Town, or                               | Location of Death                            | 110 V CIIIDCI                              | 4c. County of Dea             |  |
|   |   |                | Shady Grove H   |   |  |  | ville  |  | Montgo                        |  |
|   | Funeral<br>Director   |                | 5. Social Security Number 579–98–4134 Usual Residence of Decedent   |   | Pe (In yrs. last birthday) Yrs.            | Months Days                                      | If Under 24 Hrs. Hours Min.                  | 8. Date of Birth (Month, Day, 1)  July 21, | 9. Bir<br>1965 Wash           | thplace (State or Foreign buntry) ington D.C.    |
|   | yland<br>Iow  |                | 10a. State 10b. Count   | 1   | 10c. City, Town or Lo                      | ocation  |  |  |                               | 10d. Inside City Limits                          |
|   | a-f eh  | ctor           | MD Montg  | gomery  | Montgom                                    | ery Villa  | ge   |  |                               | ¥ Yes 2 No                                       |
|   | vith th   | Director       | 10e. Street and Number<br>19806 Bazzellt  | D1  |  | 10f. Zip Code                                    |  |  | g. Citizen of What Co         | •  |
|   | ne 23   | Funeral        | 11. Marital Status  | J2. Was Decedent  | Ever in U.S. 13                            | 20886<br>Was Decedent of H                       |  |  | United St                     |  |
| 21215-0036  | 72 hours after death with the Maryland<br>naturel; or Iteme 23a or 28e-f ehow<br>digal Exaction most be redified at | by             | 1 Never Married 2 Ma<br>3 Widowed 4 Divorce   | If Yes Give 23  | No   | If Yes, specify Cuba<br>1 ☐ Yes <b>X</b> ☐ No    | Specify:                                     | Rican, etc.)                               | Black, Whit                   |  |
| 15-0  | within 72 hours<br>jiene.<br>r then "naturel",<br>the Medical Exe   | Completed      | 15. Decede<br>(Specify only high  | nt's Education<br>ast grade completed)                                  | (Give                                      | dent's Usual Occupa                              | turina most of worki                         | ing 10                                     | 6b. Kind of Business          | Industry   |
| 12  | i filed within i Hygiene. other then "  | omp            | Elementary/Secondary (0-12)  12th   | College (1-4or  | 5+)  | po not use retired<br>rk Specia                  | •  |  | Desirate (                    | D1 ()  |
|   | Hyg<br>The  | Be C           | 17. Father's Name (First, Middle  | , Last)   | , OIC                                      | LK Specia  | 18. Mother's Name                            |  |                               | Blue Cross)                                      |
| ylar  |   | ToE            | Frank J   | ones  |  |  | Ann  |  |                               |  |
| Maryland  | 12.5<br>h ar<br>7 le  |                | 19a. Informant's Name/Relation  Traci Jones   | ship <i>(Type, Print)</i><br>— <b>wife</b>                              | 19b. Mailir<br><b>198</b> 0                |  |  |  | City or Town, State, 2        | 2000   |
|   | Tan<br>Heeling  |                | 20a. Method of Disposition  | WITE  | ce. Mont                                   | govery Vi  | Lage MD Town, State                          |  |                               |  |
| E   | 0 0   |                | tX Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (   |   | 3/05 W                                     | ashington.                                       | D C  |  |                               |  |
| Baltimore,  | permit. Pag<br>Department<br>Importent: I<br>eny Injury o   |                | John T.   | wart Fun  | eral Home                                  |  |  |  |                               |  |
|   |   |                | 23a. Part1. Enter the disease, of shock, or heart failure. Lis  | Stewart III or complications that caused to only one cause on each li   |  |  |  |  |                               | Approximate<br>Interval Between                  |
|   | Physician   |                | Immediate Cause (Final disease or condition   | _a Asthma   |  |  |  |  |                               | Onset and Death                                  |
|   | /Medical<br>Examiner  |                | resulting in death)   | Due to (or as   | a consequence of):                         |  |  |  |                               |  |
|   |   | er             | Sequentially list conditions, if any, leading to immediate cause. End Underlying Cause (Disease or injury | b. ————————————————————————————————————                                 | a consequence of):                         |  |  |  |                               |  |
|   | cuted<br>od<br>ransit   | Examiner       | triat initiated events  | G   |  |  |  |  |                               |  |
| ,<br>0,   | ifficate be executed<br>g physicien end<br>as the burial-transit  | Ex             | resulting in death) Last  | Due to (or as   | a consequence of):                         |  |  |  |                               |  |
| 68760,  | physic<br>physic<br>the b   | edical         |   | d   |  |  |  |  |                               |  |
| O. Box 6  | ath certif<br>nttending<br>or use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 ☐ Fetal death 3 ☐                        | Ectopic pregnancy Other (specify)                |  |  | 23d. Date of dei<br>Month     | ivery<br>Day Year                                |
| Δ.  | that the de<br>led by the e<br>deteched t   |                | Part II. Other significant condit   | ions contributing to death t  | out not resulting in the u                 | nderlying cause give                             | en in Part I.                                | 23e. Did toba                              | cco use contribute to         | the cause of death?                              |
| rds   | quires<br>on sign<br>uld be   | ed by          |   |   |  |  |  | 1 ☐ Yes                                    | 2 □ No 3 □ Pr                 | obably 4 XUnknown                                |
| of Vital Records,   | The law requisete has been page 2 shoul   | Completed      |   |   |  |  |  | 24a. Was an autopsy performe               | prior to                      | itopsy findings available completion of cause of |
| /ita  | certific<br>rector.   | Be             | 25. Was case referred to medic examiner?  |   |  |  | 26. Place of Death                           | Check only one                             |                               |  |
| <del>_</del>  | Phys<br>this<br>aldi  | 1°             | 12 Yes 2 □ No   | Hospital: 1 Inpatie   |  |  | 4   Nursing nor                              |  | ce 6 □Other (Spe              | cify)  |
| 27. Manner of Death 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 |   |                |   |   |  |  |  |  |                               |  |
| Division  | at or Attending<br>setter deeth.<br>I Director: After<br>d in by the fune   | Certification: | 3 ☐ Suicide 6 ☐ Could   | not be 28e. Place of In   | jury - At home, farm, str<br>tc. (Specify) |  |  | 28f. Location (Stre<br>City or Town,       | et and Number or Ru<br>State) | ural Route Number,                               |
|   | Hospita<br>24 hours<br>Funera<br>tely fille   | Medical C      | 29a Certifier (Check only one)  | I Examiner: On the basis of and manner st                               | of examination and/or in                   | h considered at the two<br>vestigation, in my op | na date and place, a<br>pinion, death occurr | and due to the eau<br>ed at the time, dat  | e and place, and due          | stated. to the cause(s)                          |
|   | To the<br>within 2<br>To the<br>comple  | M              | 29b. Signature and title of certific  | er / 1  |  | 29c. License                                     | number                                       | 290  | d. Date signed (Mont          | h, Day, Year)                                    |
| •   |   |                | • //  | Llas M  | ARM CRIPPLE                                | - M  | C.M.E.                                       | No   | vember 21,                    | , 2005   |
| _   | 10  |                | 30. Name and address of person  | RUBIO, MS   | 111  | Penn Str   | eet, Balt                                    | imore, M                                   | aryland 21                    | .201   |
|   | Sta<br>Registi  |                | 31. Date filed (Month, Day, Year DEC 2 9 2005   | 32. Registr   | rar's Signature                            |  |  |  |                               |  |

|             |   |                | For<br>State<br>Registrar   | State of  | Marylar  |                                  | artment<br>rtificate   |                    |                            | nd Me                     | 6                                      | ene ()                       | 5 4                          | 208                                    | 6                  |
|-------------|---|----------------|---|---|--|----------------------------------|--|--------------------|----------------------------|---------------------------|--|------------------------------|------------------------------|--|--------------------|
| 500         | Physici   | an             | 1. Decedent's Name (First, Middle   | , Last)   | _  |                                  | 20,  |                    |                            |                           | Date of Death<br>Month                 | Day                          | Year                         | 3. Time of I                           |                    |
|             | /Medio<br>Examin  |                | 4a. Facility Name (If not institution The Johns   | give street and numb<br>Hopkins F                                 | 2 12   | 4/                               | 4b. City, To   | wn, or             |                            | Death                     | lecember<br>Ly                         |                              | y of Death                   | 10:48                                  |                    |
|             | Funeral<br>Director   |                | 5. Social Security Number 216–36–4959   | 6. Sex 7.   | Age (In yrs.   | last birthday)<br>Yrs.           | If Under 1<br>Months [   | Year<br>Days       | If Under 2<br>Hours        | Min. 8                    | Date of Birth<br>(Month, Day,<br>7-29- |                              | 9. Birthpi<br>Coun           | ace (State or<br>try)                  | Foreign            |
|             | the Maryland<br>28a-f ehow<br>notified at   | Director       | Usual Residence of Decedent  10a. State  10b. County  Md.  10e. Street and Number   | NA  | 10c. Cit   | y, Town or Lo                    |  | ode                |                            |                           | 10                                     | g. Citizen of                |                              | od. Inside City Yas                    |                    |
|             | 3a or   |                | 2310 Jefferso   | n Street  |  |                                  |  | 2120               | 15                         |                           |  | usa<br>Usa                   |                              | uy:                                    |                    |
| 9036        | d within 72 hours after death with the Maryland<br>jone.<br>Ir then "natural", or itame 23a or 28a-f ehow<br>If a Mexical Exactiner must be notified at | d by Funeral   | 11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced  | 12. Was Decede  | es?<br>☑ No  |                                  | Was Deceder<br>If Yes, specify   | nt of His<br>Cuban | panic Origi                | in? (Specif<br>Puerto Ric | y Yes or No-<br>an, etc.)              | 14. Ra                       | ce - America<br>ck, White, e |  |                    |
| 21215-0036  | within 72 h<br>ene.<br>then "natu   | Completed      | 15. Decedent (Specify only highes Elementary/Secondary (0-12)   | s Education<br>t grade completed)<br>College (1-4                 | or 5+)   | (Give                            | dent's Usual (<br>kind of work of<br>DO NOT use  | done du            | uring most                 | of working                | 1                                      | 6b. Kind of B                | Business/Ind                 | ustry                                  |                    |
|             | filed w<br>Hygier<br>other th   |                | 7th grade  17. Father's Name (First, Middle, 1  | act)  |  | En                               | virome   |                    |                            |                           | First, Middle, M                       | Unive                        | rsity                        | Hospi                                  | tal_               |
| Maryland    | D a a b   | To Be          | Ernest  | .231)   | V  | atson                            |  |                    |                            | salee                     |  | aiden Sumai                  | <sup>me)</sup><br>Wats       | son                                    |                    |
| ary         | 2 should be and Ment is marked aumatic e  |                | 19a. Informant's Name/Relationsh  | ip (Type, Print)  |  | 19b. Mailir                      | ng Address (S  | treet a            | nd Number                  | or Rural R                | oute Number,                           | City or Town                 |                              |  |                    |
|             | ss 1 and<br>of Heelth<br>Itam 27<br>r other tr  |                | Rosemary Jones  20a. Method of Disposition  12 Burial 2 Cremation   | 3 □Removal from Sta   | 20b. F   | Place of Dispo<br>cometery, crer | sition (Name<br>natory or othe   | of                 | )                          | Date                      |  | Oc. Location                 | - City or To                 |  |                    |
| Baltimore,  | permit. Page<br>Department of<br>Importent: if<br>any injury or   |                | 21. Signature of Funer (Service)  |   | 1  |                                  | Cem.<br>Name and A<br>larch F  |                    | of Facility                |                           | _                                      | Dundall<br>Imore,<br>North   | Md.                          | 21202                                  |                    |
|             | Physician<br>/Medical   |                | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition) resulting in death)    | a   | n line.<br>Oneur   | nonia                            | er the mode o  | of dying           | , such as c                | ardiac or re              | espiratory arres                       | st.                          |                              | Approximate Interval Betw Onset and Do | een                |
| 8760,       | Examine be executed physicien and the burial-transit  | dical Examiner | Sequentially list conditions, and accause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. — Due to (or   | as a consequence as a c | wence off:                       |  |                    |                            |                           |  |                              |                              |  |                    |
| P.O. Box 6  | ne death certifi<br>the attending I<br>thed for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Yno 9 □ Unknown  | 23c. If yes, outco<br>1 □ Live birth<br>4 □ Pregnan<br>9 □ Unknow | t at time of d   | I death 3                        | Ectopic preg<br>Other (speci   |                    |                            |                           |  |                              | ate of deliver               | ,                                      | ear .              |
|             | w requires that the bod by should be detact   | by             | Part II. Other significent conditio   | 1/  | h but not res<br>tens!   |                                  | nderlying caus   | se giver           | n in Part I.               |                           | 23e. Did toba                          | 2 No                         |                              | e cause of dea                         |                    |
| al Records, |   | Completed      | Mitral!   | Valve :   | Sten   | 0515                             |  |                    |                            | _                         |  | ed?                          | prior to com<br>death?       | sy findings av                         | vailable<br>use of |
| Vital       |   | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  | Hospital:   |  | 5D/0                             |  | Other              |                            |                           | check onlone                           |                              |                              |  |                    |
| Division of | Attending Physic death.  •ctor: After this by the funeral di  | ation; To      | 27. Manner of Death  1 Partial 5 Pending  2 Accident investig   | 28a. Date of I<br>(Month,   |  | 28b. Time of<br>Injury           |  | Injury :<br>Work?  | at Nurs                    | 28d                       | 5 Residen  I. Describe how             |                              |                              |  |                    |
| Divis       | i Diffe   | Certification  | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi   |   | Injury - At ho<br>etc. (Specif   | ome, farm, str                   | eet, factory, o  | ffice              |                            | 28f.                      | Location (Stre<br>City or Town,        |                              | er or Rural                  | Route Numbe                            | er.                |
|             | To the Hospitei<br>within 24 hours a<br>To the Funerei I<br>completely filled   | edical         | 29a. Certifier 1 Certifying (Check only one)  | Physician: To the be<br>examiner: On the basi<br>and manner       | s of examina   | wledge, death<br>tion and/or inv | occurred at the occurred at th | ny opi             | e, date and<br>nion, death | place, and<br>occurred    | due to the cau<br>at the time, dat     | se(s) and ma<br>e and place, | anner as sta<br>and due to   | ted.<br>the cause(s)                   |                    |
|             | To the<br>within 2<br>To the<br>complet   | Me             | 29b. Signature and title of certifier   |   |  |                                  | 29c. L   | icense             | number                     |                           | 290                                    | d. Date signe                | d (Month, D                  | ay, Year)                              |                    |
| <b>)</b>    | 0   |                | Sinter  | Don 1   | 1.0.   |                                  | K  | 3                  | 5-0                        | 00                        | L                                      | Pecem                        | ber Z                        | 7,200                                  | 25                 |
|             | )   |                | 30. Name and address of person of Santosh Oomne. 31. Date filed (Month, Day, Year)  | vno completed cause of  | North  | 1 23a) (Type,<br>2 Wo / f        | Print) Pe 5  | tr                 | eet                        | -,                        | 290<br>L<br>Baltt                      | More,                        | Mar                          | yland                                  | Z/287              |
|             | Sta<br>Registr  | - 1            | DFC 2 9   | 2005  | ELI A  | K Lyn                            | seles  |                    |                            |                           |  |                              |                              |  |                    |

|  |  |                   | For State Registrar   | State of N   | Maryland         |                                |                           | t of H              | ealth a                    | and M                     | ental Hy                               | giene                        | 5                         | 42087  |
|--|--|-------------------|---|--|------------------|--------------------------------|---------------------------|---------------------|----------------------------|---------------------------|--|------------------------------|---------------------------|--|
|  | Dhuaisi  | 2                 | Decedent's Name (First, Middle, I   | Last)  |                  |                                |                           |                     |                            |                           | 2. Date of De                          |                              | Year                      | 3. Time of Death                                   |
|  | Physici<br>/Medic  |                   |   |  | NN1              | NGS                            |                           |                     |                            |                           | SECEMP                                 | ER 26                        | 2005                      | 3'40PM   |
|  | Examin   | er                | 4a. Facility Name (If not institution, g  |  | •                | LANG                           |                           |                     | Location of                |                           |  |                              | y of Death                |  |
|  | Eupovol  | -                 |   | EN NUR   | ge (In yrs. la   |                                | M C                       |                     | If Under                   | 24 Hfs.                   | 8. Date of Birt                        |                              | RQO<br>9. Birthi          |  |
|  | Funeral Director   |                   | 214-40-5404   | 1 □ M 2 □XF  | 87               | Yrs.                           | Months                    | Days                | Hours                      | Min.                      | July 2                                 | , Year 918                   | Coul                      | place (State or Foreign<br>MD                      |
|  | pu 🖈   |                   | Usual Residence of Decedent  10a. State 10b. County   |  | 100 City         | , Town or Lo                   |                           |                     |                            |                           |  |                              |                           |  |
|  | faryla<br>shov   | 5                 |   | ward   |                  |                                |                           | _                   |                            |                           |  |                              |                           | 10d. Inside City Limits 1 □Yes 2√□ No              |
|  | the N  | rect              | 10e. Street and Number  | waru   | LI               | licot                          | 10f. Zip                  |                     |                            |                           |  | 10g. Citizen of              | What Cour                 |  |
|  | h with   | Funeral Director  | 8241 Academy Ro   | oad  |                  |                                |                           |                     | 043                        |                           |  | US                           |                           | ,  |
|  | ems 2  | ner               | 11. Marital Status  | 12. Was Deceder<br>Armed Forces                              |                  | S. 13.1                        | Was Deced                 | lent of Hi          | spanic Ori                 | gin? (Spe                 | cify Yes or No<br>Rican, etc.)         | - 14. Ra                     | ce - Ameni                |  |
| 36   | s afte   | by Fu             | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 €  | ] No             |                                | 1□Yes                     |                     | Specify:                   | ,,                        |  | Speci                        |                           | nite   |
| 9  | hour<br>stural   | ed b              | 15. Decedent's  | Year or Dates<br>Education                                   | :                | 16a. Dece                      |                           |                     | ation                      |                           |  | 16b. Kind of E               | . , ,,1                   |  |
| 21215-0036   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23c or 28a-f show<br>ther, the Mydical Exam.  | Completed         | (Specify only highest of Elementary/Secondary (0-12)  | grade completed)  College (1-4o                              | r 5+)            | (Give                          | kind of wor<br>DO NOT us  | k done a            | furing most                | t of workin               | ig .                                   | TOD. TAILO OF E              | )                         | addity   |
|  | ygien<br>ygien<br>yerth<br>t, the  | Соп               |   | 4  | ,                |                                | Teach:                    | er                  |                            |                           |  |                              | cation                    | n  |
| Maryland   | be fill<br>hall H<br>had off<br>even   | Be                | 17. Father's Name (First, Middle, La<br>John McA11  |  |                  |                                |                           | İ                   |                            |                           |  | Maiden Suma                  | me)                       |  |
| Ž  | should be fand Mental be smarked of  | ပို               | 19a. Informant's Name/Relationship  |  |                  | 19h Mailir                     | na Address                | (Street a           |                            |                           | ine Kot                                | ne<br>ar, City or Town       | State Zin                 | Codol  |
| Ma   | nd 2 saith ar  |                   | Mr. Richard Niebe   | orline No.   | xt of<br>Kin     |                                |                           |                     |                            |                           |  | ty, MD                       |                           |  |
| Je,  | of Heal  |                   | 20a. Method of Disposition  |  | 20b. Pla         | ace of Dispo                   | sition (Nan               | ne of<br>ther place | e)                         | Da                        | ate ·                                  | 20c. Location                | - City or To              | own, State   |
| <u>ii</u>  | Page<br>nent c<br>ant: If<br>ury or  |                   | 1 ☐ Burial 2 [X]Cremation 3 14 ☐ Donation 5 ☐ Other (Spe  |  | °   All          | Count                          | ty Cr                     | emat:               | ion                        | 12/3                      | 30/05                                  | Sykesvi                      | .11e,                     | MD   |
| 10a. State   10b. County   10c. City, Town or Location   10d. Inside the property of the pro |  |                   |   |  |                  |                                |                           |                     |                            | 195)                      |  |                              |                           |  |
|  |  |                   | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on                                    | ry one cause on each   | line.            | . Do not ent                   | er the mod                | e of dying          | g, such as                 | cardiac or                | respiratory ar                         | rest.                        |                           | Approximate<br>Interval Between<br>Onset and Death |
|  | Pnysician<br>/Medical  |                   | Immediate Cause (Final disease or condition resulting in death)   | a  | Bror             |                                | - PN                      | EUM                 | 4001                       | <del>`A</del>             |  |                              | C                         | ne work  |
|  | Examiner   |                   |   | Due to (or a   | is a consequ     | ence of):                      |                           |                     |                            |                           |  |                              | 1                         |  |
|  |  | Jer               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury | b. — Due to (or a  | is a consequ     | ence of):                      |                           |                     |                            |                           |  |                              |                           |  |
| 19   | ocuted<br>nd<br>transit  | Examiner          | that initiated events   | C  |                  |                                |                           |                     |                            |                           |  |                              |                           |  |
| 90,  | ate be executed<br>tysician and<br>he burial-transit   |                   | resulting in death) Last  | Due to (or a   | is a consequ     | ence of):                      |                           |                     |                            |                           |  |                              |                           |  |
| 8760,  | physics the t  | Physician/Medical |   | d  |                  |                                |                           |                     |                            |                           | ······································ |                              |                           |  |
| Вох 6  | death certifica<br>attending ph<br>d for use as th   | √Me               | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcom  |                  |                                |                           |                     |                            |                           |  | 23d Da                       | ate of delive             | any  |
|  | death<br>e atter   | iciar             | in the past 12 months?  | 1□Live birth<br>4□Pregnant                                   |                  |                                | Ectopic pro<br>Other (spe |                     |                            |                           |  |                              | onth                      | Day Year   |
| P.0  | that the de<br>ned by the a<br>detached  | hys               | 9 Unknown   | 9□ Unknown   |                  |                                |                           |                     |                            |                           |  |                              |                           |  |
|  | ires tha<br>signed I<br>d be det   | by                | Part II. Other significant conditions   | _  | but not resul    |                                | nderlying ca              |                     | in in Part I.              |                           | 23e. Did to                            |                              |                           | ne cause of death?                                 |
| Ö  | w requir<br>been si<br>should  | eted              |   | ) IUR  | JER              | 00                             | مرد                       |                     | -                          |                           |  |                              |                           |  |
| Vital Records,   | he law<br>s has<br>ge 2 t  | Completed         |   |  |                  |                                |                           |                     |                            |                           | 24a. Was autop                         |                              | prior to cor<br>death?    | psy findings available mpletion of cause of        |
| ta   | ding Physician: The<br>h.<br>After this certificate hi<br>funeral director, page   | o o               | 25. Was case referred to medical  |  |                  |                                |                           |                     | 26 Place                   | of Death                  | 1 ☐ Yes<br>Check onl o                 | 2 No                         | 1 🗌 Yes                   | 2⊠No   |
|  | Physicil<br>this cer<br>al direct  | ToB               | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital: 1   Inpa   | tient 2 🗆 E      | R/Outpatien                    | t 3 🗆 DO                  | A Othe              |                            |                           |  | ence 6 Oti                   | ner (Specify              | y)   |
| n of   | ding Pt<br>I.<br>After th<br>funeral   |                   | 27. Manner of Death 1 ☑Natural 5 ☑ Pending  | 28a. Date of in<br>(Month, D                                 | jury<br>ay Year) | 28b. Time of<br>Injury         | 21                        | Bc. Injury<br>Work  | at<br>?                    | 21                        | 8d. Describe h                         | ow injury occur              | red                       |  |
| Division   | I or Attendi<br>after death.<br>Director: A<br>I in by the fu  | icati             | 2 Accident investigat 3 Suicide 6 Could not   | be 200 Place of I  | njury - At hor   | ma farm at-                    | M                         |                     | /es 2□h                    |                           | 96 Lanatian /F                         | New and a sense of the least | h                         | 10-1-1   |
| Di∨  | after<br>Direct  | Certification:    | 4 Homicide determine  | building,  | etc. (Specify)   | )                              | өөі, іассогу              | , once              |                            | 2                         | City or Tow                            | n, State)                    | oer or mura               | il Route Number,                                   |
|  | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical C         | 29a. Certifier (Check only one)  1 Certifying 2 Medical Ex  | Physician: To the bes<br>aminer: On the basis<br>and manners | of examination   | viedge, death<br>on and/or inv | occurred a vestigation,   | at the timi         | e, date and<br>inion, deat | d place, ar<br>th occurre | nd due to the o                        | cause(s) and made and place, | anner as st<br>and due to | ated. the cause(s)                                 |
|  | To th<br>withir<br>To th<br>comp   | Me                | 29b. Signature and title of certifier   | 000  |                  |                                | 29c.                      | License             | number                     | 1 0                       | 1                                      | 29d. Date signe              | d (Month,                 | Day, Year)   |
|  | . 7  |                   | N. 6  | LUZO .   |                  |                                |                           | D.                  | 504                        | 69                        | C                                      | Rosela                       | 27                        | Day, Year)   |
|  | 10   |                   | N. V.C LL ANKI)   |  |                  |                                | Print)                    | Parle               | every.                     | <b>A</b> :                | 308 (                                  | io (umbi                     | q. M                      | 0.21045  |
| *  | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year) DEC 2 9 2   | 005 Regis  | trar's Signatu   | ure Con                        | N.                        |                     |                            |                           |  |                              |                           |  |

|              |  |                   | 1 - For<br>State<br>Registrar  | State of Ma  | ryland / Depa<br><i>Cer</i>                              | artment of tificate of   |   | Mental Hy                               | giene                                    | 5 42   | 088  |
|--------------|--|-------------------|--|--|--|--|---|---|--|--|--|
|              | Physici  |                   | Decedent's Name (First, Middle, Las  | ,  | seph Jenki   | ns.  |   | 2. Date of De<br>Month<br>Decemb        | eath                                     | Vear   | Time of Death  |
|              | /Medio<br>Examir   |                   | 4a. Facility Name (If not institution, give Baltimore Washin   |  | al Center  |  | or Location of Dea<br>Burnie                          |   | 4c. County                               |  |  |
|              | Funeral<br>Director  |                   | 5. Social Security Number 6. Se 215 30 8765  | -  | (In yrs. last birthday)<br>72 Yrs.                       | If Under 1 Yea<br>Months Days                                      |   | (Month, D                               | rth                                      |  | e (State or Foreigr<br>and                               |
|              | e Maryland<br>Ba-f ehow  | ctor              | 10a. State 10b. County  Maryland Anne Ar   | undel  | 10c. City, Town or Lo<br>Glen Bu                         |  |   |   |  | 1  | Inside City Limits                                       |
|              | ath with th  | ral Directo       | 10e. Street and Number<br>1462 Pleasantv   | ille Drive   |  | 10f. Zip Code  | .061  |   | 10g. Citizen of U.S.                     | ,  |  |
| 030          | 72 hours after death with the Maryland<br>Instural; or Rems 23s or 28s-f ehow<br>Itsal Examinat must be notified at  | by Funeral        | 11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced   | 12. Was Decedent E<br>Armed Forces?<br>1. ☑ Yes 2 □ N<br>If Yes, Give<br>Year or Dates.K   | lo I   | Was Decedent of<br>f Yes, specify Cu<br>I ☐ Yes 2 No               | Hispanic Origin? (5<br>ban, Mexican, Puer<br>Specify: | Specify Yes or No<br>to Rican, etc.)    |  | ce - American I<br>ck, White, etc.<br>y: White | ndian,   |
| 21215-0036   | within 72<br>ene.<br>than "na'   | Completed         | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>12th   |  |  | lent's Usual Occi<br>kind of work don<br>DO NOT use retir<br>olman | upation<br>e during most of wo<br>ed)                 | orking                                  | Baltimo<br>Police                        |  | y  |
| yland        | should be filed<br>ind Mental Hygi<br>marked other<br>umatic event, ii   | To Be C           |  | Wilbur Je  |  |  | Mar   | ie Sinno                                |  | ,  |  |
| e, Mar       | 1 and 2 shou<br>Health and M<br>em 27 le mar<br>ther treumat   |                   | 19a. Informant's Name/Relationship (7.  Vicky Fauver / D.  20a. Method of Disposition  |  |  | ogan Dri   | ive We:   |   | er, Mary                                 | land 2   | 1157   |
| Saltimore    | permit. Pages<br>Department of I<br>Important: If Ite<br>any injury or of<br>once.   |                   | 1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   | )  | Bayview (  | natory or other pl<br>Cremator                                     | y 12/2  | 28/2005                                 | Baltimo                                  | re, Mar  | ryland   |
| Pa           | Departies of the control of the cont |                   | 21. Signature of Funeral Service Licens  | nomue  | cupi 4   | JUI Rite   | ress of Facility (<br>hie Highw                       | way Bal                                 | timore,                                  | Marylar  | nd 21225   |
|              | Physician<br>/Medical  |                   | 23a. P.Inf. Enter the disease, or ome<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)    | a. AC  | е.   |  | ing, such as cardia                                   |   |  | Inte<br>On                                     | proximate<br>erval Belween<br>set and Death<br>) -60 M/N |
|              | cate be executed physicien and the burial-transit  | I Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. CoRu  | D NARY A a consequence of):  PERLIPID a consequence of): |  | DISEA   | -56                                     |  | Ye   | TARS   |
| O. Box 68/60 | death certifi<br>e attending I<br>ed for use as  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | 23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown   | 2 Fetal death 3  | Ectopic pregnand   | су  |   |  | te of delivery<br>inth Day                     | / Year   |
| ecords, P    | w requires that the<br>been signed by th<br>should be detache  |                   | Part II. Other significant conditions co   |  | it not resulting in the ur                               | nderlying cause g  | ıven in Part I.                                       |   | tobacco use cont                         | nbute to the ca                                |  |
| Ï            | The law<br>ete has b<br>page 2 sl  | Completed by      |  |  | 70 000.00  |  |   | 24a. Was<br>aulo<br>perfo<br>1 🗆 Yes    | omed?                                    | Were autopsy for to comple death?              | findings available<br>lion of cause of                   |
|              | r Attending Physician: The er death. rector: Atter this certificete iby the funeral director, pag  | atlon: To Be      | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation                                   | Hospital: 1 Inpatier  28a. Date of Injur (Month, Day   | y 28b. Time ol   | 28c. Inju  | ther: 4 🗌 Nursing I                                   |   | one)<br>dence 6 Oth<br>how injury occurr |  |  |
| DIVISION     | 0 # 5 5  | Certification:    | 3 Suicide 6 Could not be 4 Homicide determined   | building, etc  |  |  |   | City or To                              | ,  |  |  |
|              | To the Hospitel within 24 hours a To the Funerel completely filled   | Medical           | one)   | ysicien: To the best of iner: On the basis of and manner sta   | I my knowledge, death<br>examination and/or inv<br>ted.  | estigation, in my  | opinion, death occu                                   | e, and due to the<br>urred at the time, | date and place,                          | and due to the                                 | cause(s)   |
|              | P ₹ 6 6  |                   | 29b. Signature and title of contilier  | Um.  |  | 1 368  | <u> </u>  |   |  | 7105   |  |
| 51           |  | 2                 | 30. Name and address of person whole  (ARLOS D. Z(6E)  31. Date liled (Month, Day, Year)   | completed cause of de  | Suffering (Type, 1) Suffering (106) r's Signature        | Print)<br>1406 S.C   | RAIN HW   | 1, GUEN                                 | BURNA                                    | E MS   | 21061  |
| The state of | Sta<br>Registi   |                   | DEC 2 9 20   | 05 Annual State of the State of | A April  | and I  |   |   |  |  |  |

|  |                            | 1 - For State Registrar  1. Decedent's Name (First, Middle, L.  |                                     |                                  |                | imoate                                  | 0                  | Jean                      |                 | 2. Date of De                   |                     |                        | 3. Time of Death                |
|--|----------------------------|---|-------------------------------------|----------------------------------|----------------|---|--------------------|---------------------------|-----------------|---------------------------------|---------------------|------------------------|---------------------------------|
| Physic   |                            | Frank Kennelty  |                                     |                                  |                |   |                    |                           |                 | Month                           | Day                 | Yeer                   |                                 |
| /Medi<br>Examir  |                            | 4a. Fecility Name (If not institution, gi   |                                     | er)                              |                | 4b. City,                               | Town, or           | Location                  | of Death        | Decemb                          |                     | 2005<br>nty of Death   | 12:48 PM                        |
|  |                            | 202 W. 5th Str  | eet                                 |                                  |                | Fı                                      | rede               | rick                      |                 |                                 | F                   | reder                  | ick                             |
| Funeral  |                            |   | Sex 7<br>1 1 3 7 M 2 □ F            | Age (In yrs. I                   | ,,             | If Under<br>Months                      | 1 Year<br>Days     | If Under<br>Hours         | 24 Hrs.<br>Min. | 8. Date of Birt<br>(Month, Da   | y, Year)            | 9. Birthp              | place (State or Foreigntry) unk |
| Director   |                            | 161-38-7588 Usual Residence of Decedent   | X                                   | 61                               | Yrs.           |   |                    |                           |                 | Apr 10                          | , 1944              | 1                      |                                 |
| land<br>IOW  |                            | 10a. State 10b. County  |                                     | 10c. City                        | , Town or Lo   | ocation                                 |                    |                           |                 |                                 |                     | 1                      | Od. Inside City Limits          |
| within 72 hours after death with the Maryland<br>ene.<br>than "natural", or itams 23a or 28a-f ahow<br>ha Mazilan Examinar musi be notified at   | to                         | MD Frede  | erick                               |                                  | Frede          | rick                                    |                    |                           |                 |                                 |                     |                        | 1 ☐ Yes 2 ☐ No                  |
| or 28g   | irec                       | 10e. Street and Number  |                                     |                                  |                | 10f. Zip                                | Code               |                           |                 |                                 | 10g. Citizen o      | of What Cour           | ntry?                           |
| 23m C  | a                          | 202 W. 5th Str  | eet                                 |                                  |                |   |                    | 2170                      | 01              |                                 | Į                   | JSA                    |                                 |
| nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Modical Externationals traumatic event, the Modical Externationals. | by Funeral Director        | 11. Marital Status  | 12. Was Decede<br>Armed Force       | s?                               | S. 13.         | Was Deced                               | ent of Hi          | ispanic Ori<br>n, Mexicar | gin? (Sp        | ecity Yes or No<br>Rican, etc.) | 14. R               | ece - Americ           |                                 |
| 9 8  | y F.                       | 1 Never Married 2 Married   | 1 ☐ Yes 2                           | No                               |                | 1 □ Yes 2                               |                    | Specify:                  |                 |                                 | Spec                |                        | ite                             |
| tural<br>E.E.  | q pa                       | 3 Widowed 4 Divorced  | Year or Date:                       | s:                               | 162 Dogg       | dont's Heur                             | I Ossusa           | ation                     |                 |                                 | 16h Kind of         |                        |                                 |
|  | Completed                  | 15. Decedent's E<br>(Specify only highest gi  | ade completed)                      |                                  | (Give          | dent's Usua<br>kind of wor<br>DO NOT us | k done d           | during mos                | t of work       | ing                             | 16b. Kind of        | business/in            | dustry                          |
| the  | E                          | Elementary/Secondary (0-12)   | College (1-4d                       | or 5+)                           |                | custo                                   |                    | ,                         |                 |                                 | 0.000.00            |                        |                                 |
| Hyg<br>other   | BeC                        | 17. Father's Name (First, Middle, Las   |                                     |                                  |                |   | nk                 |                           | er's Name       | e (First, Middle,               | Cance<br>Maiden Sum |                        | unk                             |
| Mental<br>arked c  | To B                       |   |                                     |                                  |                |   |                    |                           |                 |                                 |                     |                        | arric .                         |
| is ma  |                            | 19a. Informant's Name/Relationship  | (Type, Print)                       |                                  | 19b. Mailin    | ng Address                              | (Street a          | and Numbe                 | or Rur          | al Route Numbe                  | er, City or Tow     | m, State, Zip          | Code)                           |
| Health   |                            | Fay White/friend  |                                     |                                  | 429            | N. Ber                                  | ntz                | Stree                     | t F             | redericl                        | s. Mi)              | 21701                  |                                 |
| of He<br>fitan   |                            | 20a. Method of Disposition  1  Burial 2  Cremation 3  | Domewal from Sta                    |                                  | ace of Dispo   | sition (Nam                             | ne of              |                           | ĺ               | Date                            | 20c. Location       | n - City or To         | own, State                      |
| 2 2 6  |                            | '4 □Donation 5 ☑ Other (Spec  |                                     | - 1                              |                |   |                    |                           |                 |                                 |                     |                        |                                 |
| Department of Healimportant: If Itam<br>any Injury or othe   |                            | 21. Signature of Euneral Service Lice<br>Ronald S   | nsee, /                             | rector                           | 22             | 2. Name and                             | d Addres           | s of Facilit              | у               | 655 TI                          | D - 1 - 4           | - 6                    |                                 |
| ₫ <b>₽ 8</b>   |                            | / Jman/1  | 1/1/44                              |                                  |                |   |                    |                           |                 | 1 <sup>655</sup> W.             |                     | more S                 | treet                           |
|  |                            | 23a. Part Enter the diseas, or cor<br>shock or heart failure. List only                                     | nplications that cause on each      | sed the death                    | . Do not ent   | er the mode                             | e of dying         | g, such as                | cardiac         | or respiratory ar               | rest,               | _0                     | Approximate<br>Interval Between |
| ysician  |                            | Immediate Cause (Final disease or condition   | Sud                                 | den                              | Cardo          | air (                                   | arre               | sti                       | i to            | Coro                            | ray a               | utry                   | Onset and Death                 |
| Medical  |                            | resulting in death)   | 0                                   | u Jest                           | re             |   |                    |                           |                 |                                 |                     |                        |                                 |
| aminer   |                            | Sequentially list conditions.   | b. Lung cancer                      |                                  |                |   |                    |                           |                 |                                 |                     |                        |                                 |
| 75   | ine                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury | Due to (or                          | Due to (or as a consequence of): |                |   |                    |                           |                 |                                 |                     |                        |                                 |
| and<br>I-tran  | Examiner                   | that initieted events resulting in death) Last  | c. Due to (or as a consequence of): |                                  |                |   |                    |                           |                 |                                 |                     | -                      |                                 |
| ician<br>buria   |                            | 4   | 11                                  | MDP ~                            | So da          | 200                                     |                    |                           |                 |                                 |                     |                        |                                 |
| physician and<br>s the burial-transit  | dicai                      | •   | d                                   | 110                              | or Cor.        |   | ~                  | 4                         |                 |                                 |                     |                        |                                 |
| D) 42  | /Me                        | IF FEMALE:  | 23c. If yes, outcon                 | ne of pregnar                    | ncv            |   |                    |                           |                 |                                 |                     |                        |                                 |
| ed by the attendir<br>detached for use   | cian                       | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live birth<br>4 ☐ Pregnant      | 2 ☐ Fetal                        | death 3        | Ectopic pre                             |                    |                           |                 |                                 |                     | ate of delive<br>Month | Day Year                        |
| y the  | ıysi                       | 1 □ Yes 2 □ No<br>9 □ Unknown   | 9□ Unknown                          |                                  |                | 1 Oll 10 (3)                            | JOHY               |                           |                 |                                 |                     |                        |                                 |
| bed b  | Completed by Physician/Med | Part II. Other significant conditions   | contributing to death               | but not resu                     | Iting in the u | nderlying ca                            | use give           | n in Part I.              |                 | 23e. Did to                     | bacco use co        | ntribute to th         | ne cause of death?              |
| s been signed to<br>should be det  | d b                        | hyperchol   | estrolen                            | a,                               | CO             | PD                                      | ,                  |                           |                 | 1 🗆 Y                           | es 2□No             | 3 🗀 Prob               | ably 4 Unknown                  |
| shou   | iete                       | colinie)  | Dalus                               | R                                |                |   |                    |                           |                 | 24a. Was                        | an 24h              | . Were auto            | psy findings available          |
| e has  | E C                        |   | 1 94                                |                                  |                |   |                    |                           |                 | autop<br>perfo                  | sy<br>med?          | prior to con<br>death? | impletion of cause of           |
| is certificate has<br>director, page 2   | Ö                          | 25. Was case referred to medical  |                                     |                                  |                |   |                    | OR Plane                  | -4.0            |                                 | 2XNo                | 1 🗆 Yes                | 2□ No                           |
| s cert   | To B                       | examiner?<br>1 □ Yes 2 <b>X</b> No  | Hospital:                           | atient 2 🗆 E                     | ER/Outpatier   | nt 3□ DO/                               | Othe               |                           | rsing Ho        | n (Check only o                 |                     | that (Carris           | ad .                            |
| ₽ =  |                            | 27. Manner of Death   | 28a. Date of Ir                     | njury                            | 28b. Time of   |   | Bc. Injury<br>Work |                           |                 | 28d. Describe h                 | lence 6 🗆 O         |                        | 7)                              |
| within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   | atio                       | 1 X Natural 5 ☐ Pending 2 ☐ Accident investigate  |                                     | Day Year)                        | Injury         | м                                       |                    | (?<br>∕es 2 🔲 I           | No              |                                 |                     |                        |                                 |
| ecto<br>by th  | i i                        | 3 ☐ Suicide 6 ☐ Could not determined  | 28e. Place of                       | Injury - At hore                 | me, farm, str  | eet, factory,                           | office             |                           |                 |                                 |                     | nber or Rura           | I Route Number,                 |
| al Dir   | Certification:             | T I I I I I I I I I I I I I I I I I I I   | Dalland,                            | etc. (Specify                    | ,              |   |                    |                           |                 | City or Tow                     | m, State)           |                        |                                 |
| winin za nours arer deam.<br>To the Funeral Director: After th<br>completely filled in by the funeral  |                            | 29a. Certifier 1 Certifying P   | hysician: To the be                 | st of my know                    | vledge, death  | n occurred a                            | at the tim         | e, date an                | d place,        | and due to the                  | ause(s) and r       | nanner as si           | ated.                           |
| the F  | edical                     | one)  | miner: On the basis<br>and manner   | stated.                          | on and/or in   | vestigation,                            | in my op           | oinion, dea               | th occurr       | ed at the time, o               | date and place      | e, and due to          | the cause(s)                    |
| COLL   | Σ                          | 29b. Signature and title of certifier   | dd                                  |                                  |                | 29c.                                    | License            | number                    |                 |                                 | 29d. Date sign      | ned (Month,            | Day, Year)                      |
|  |                            | 1 100   | ina                                 |                                  |                | 1                                       | )39                | 945                       | 8               |                                 | 12/                 | 14/1                   | J >                             |
|  |                            | 30. Name, and address of person who   | completed cause o                   | death (Item                      | 23a) (Type,    | Print)                                  | )                  | Oni                       | 1               | 1/2/-                           |                     | E.                     | 121,701                         |
|  |                            | SADINA  | 11/01/                              | udo                              | (11)           | 111.6                                   | J. ,               | 801                       | 10              | 11/1/                           | USE                 | , Trec                 | xencis m                        |
| Sta  | ite                        | 31. Date filed (Month, Day, Year)  DFC 2 9 2005   | 32. Regi                            | strar's Signat                   | ure            |   | /                  |                           |                 |                                 |                     | /                      | ,                               |

Amend item#1, per Mi, G850, 12 22965 Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Walter Kandefer 2. Date of Death 3. Tima of Death Month Day Year **Physician** 2:28 AM Verembe 18 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY COLUMBIA MU HOWARD GENERAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1**⊠**M 2□F Days Hours 213-34-8135 Director 27. 1936 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location Department of Health and Mental Hygiene, Internation (teme 23a or 28a-1 show Important: if item 27 is marked other then "natural", or iteme 23a or 28a-1 show eny injury or other treumatic event, the Medical Examinar intuit be coulding at appear. 10d. Inside City Limits 1 Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10588 Spotted Horse Lane 21044 S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) 4 Years Letter Carrier Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Walter Kandeher Anna Eleanor Rickwalder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Rollison (Niece) 4947 Sinclair Lane, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 12/21/2005 Baltimore, Maryland 22 Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee Brain a lee 3331 Brehms Lane, Baltimore, Md. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 2 MUST /Medical Due to (or as a consequence of) Examiner a 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a c insequence of) Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Division of Vital Records, P. signed b Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been si 3 Probably 4 Zuriknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificete has t irector, page 2 s 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ Ne 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☑ №6 1 Thipatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 1 DNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No i Director: 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0020554 December 18 20005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1206 lade Avenue Suite 101 Bult more, 1td. 21206 600 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 2005

DHMH 17 Rev 1/2001

Registrar

|                     |   |                               | State of Maryland / Department of Health and Mental Hygiene  |                                   |
|---------------------|---|-------------------------------|--|-----------------------------------|
|                     |   | •                             | 1- State Registrar Certificate of Death Reg. No. 005 42  | 2091                              |
|                     | Physicia  | an                            | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Ti  | ime of Death                      |
|                     | /Medic<br>Examin  |                               |  |                                   |
|                     | LAGITITI  |                               | MERCY MOSPITHE BALTIMORE   |                                   |
|                     | Funeral   |                               | 5. Social Security Number 215-43-9140  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. O1/24/1930  9. Birthplace (Social Security Number (Month, Day, Year) 01/24/1930  9. Birthplace (Social Security Number 215-43-9140)  9. Birthplace (Social Security Number 215-43-9140)  | State or Foreign                  |
|                     | Director  |                               | 215-43-9140  | Corea                             |
|                     | tryland<br>thow   |                               |  | side City Limits                  |
|                     | he Ma<br>18a-f  | ecto                          | MD Baltimore XX  | ÝYes 2 □ No                       |
|                     | with t  | חַב                           | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA   |                                   |
|                     | death   | nera                          | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)  14. Race - American Indi  | ian,                              |
| 36                  | or Ite  | y Fu                          | Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  Black, White, etc.  I □ Never Married XIX Married  I □ Yes XIX No Specify: Specify: Specify: A Si OR  |                                   |
| 00                  | hours<br>ture!  | q pa                          | 3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry  |                                   |
| 215                 | be filed within 72 hours after death with the Maryland ntal Hygiene. od other than "neturel", or Items 23a or 28a-f show event, the Medical Examinar must be nutified at  | Completed by Funeral Director | (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)  |                                   |
| 21                  | filed withi<br>Hygiene.<br>other than   | Соп                           | 9 - Homemaker Own Home   |                                   |
| and                 | should be filed<br>nd Mental Hygi<br>marked other<br>matic event, I   | Be c                          | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  |                                   |
| Maryland 21215-0036 |   | ို                            | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  | )                                 |
| Ž                   | # 23 E G  |                               | Dong Kim (husband) 11 W. 20th Street Baltimore, MD 21218   |                                   |
| Baltimore,          | 00  |                               | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  |                                   |
| Itim                |   | 1 9                           | '4 Donation 5 Other (Specify) Crestlawn Memorial 12/28/2005 Marriottsville,  21. Signature of Funeral Service Licensee   |                                   |
| Ва                  | permit. Departr Importe eny inje  |                               | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Witzke Funeral Homes, In 5555 Twin Knolls Road Columbia, MD 210   |                                   |
|                     |   |                               | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximately, and the complication of the complex of the c | oximate<br>val Between            |
|                     | Physician   |                               | Immediate Cause (Final disease or condition resulting in death)  a. SEPTIC SITICK  A   | t and Death                       |
|                     | /Medical<br>Examiner  |                               | Due to (or as a consequence of):  C(RRITOS(S)  | 24.25                             |
|                     | n =   | ner                           | Sequentially list conditions D.  | -110                              |
|                     | sician and<br>burial-transit  | Examiner                      | Cause (Disease or injury that initiated events c. resulting in death) Last  Due to (or as a consequence of):   |                                   |
| 760,                | ite be executed<br>iysician and<br>ne burial-transit  | calE                          |  |                                   |
| 9                   | death certificate to attending physical for use as the E  |                               |  |                                   |
| Вох                 | ath cer<br>ttendir<br>or use  | ian/N                         | IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery Month Day  | Year                              |
| P.O. I              | The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the  | Physician/Med                 | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)   |                                   |
|                     | res that<br>igned by<br>be deta   |                               |  | se of death?                      |
| ords                | w require<br>been sig<br>should b   | ted t                         | end stage renal disease 1- Yes 2-No 3- Probably  | 4 Monknown                        |
| Vital Records,      | e lawr<br>has be<br>ge 2 sh   | Completed by                  | 24a. Was an autopsy find autopsy performed prior to completion death?  | dings available<br>on of cause of |
| alF                 | ysicien: The is certificate hadirector, page  |                               |  | lo                                |
| <u>=</u>            | Physicien:<br>this certificated director,   | To Be                         | examiner?  |                                   |
| n of                | ng Phys<br>fter this<br>neral di  |                               |  |                                   |
| Division            | death.<br>ctor: Afr   | catle                         | 2 Accident investigation  2 Accident investigation  3 Suicide 6 Could not be  3 Suicide 6 Could not be   | a Alizaba a                       |
| Divi                | after after Direct I | Certification:                | 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  3 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  3 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  7 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  3 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  6 ☐ Homicide  6 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  8 ☐ Homicide  9 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  1 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  2 ☐ Homicide  3 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Homicide  5 ☐ Homicide  5  | e Number,                         |
|                     | ospite<br>hours<br>unerel<br>ly filled  |                               |  | 21100/01                          |
|                     | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral   | Medical                       | 29b. Signature and title of certifier 29d. Date signed (Month, Day, Ye   |                                   |
| •                   | To To CO  |                               | 250. Signature automobil Cesth, W D4263-1 DEZ 25, 2  |                                   |
|                     | 2×1   |                               |  |                                   |
|                     | 0   |                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOSEPH COSTA 301 ST. PAUL PLACE BACTININE NO.  | 21202                             |
|                     | Sta<br>Registr  |                               |  |                                   |
|                     |   |                               | LOUS EMPERED AS MINERAL AS   |                                   |

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  | State of Mary   | land / Department of Health and M   | 0.00  |
|--|---|---|---|
|  | Decedent's Name (First, Middle, Last)   | Certificate of Death  | Reg, No. 2 2 2 2. Dete of Death 3. Time of Death  |
| Physician<br>/Medical  | Anna M. Karvasek  |   | Month Day Year 835  |
| Examiner   | 4a Fecility Neme (If not institution, give street and number)  S. Social Security Number  219-30-7977  1□ M 2☑ F 96   | yrs. last birthday) Yrs. last birthday) Yrs. last birthday) Yrs. last birthday) Yrs. last birthday) Yrs. last birthday) Yrs. last birthday) Yrs. last birthday) Houris Min. | 8. Date of Birth (Month, Dev. Year)  9. Birthplace (State or Foreign Country)                               |
| Director   | Usuel Residence of Decedent   | 113.  | July 27, 1909 Maryland  |
| ryland   |   | c. City, Town or Location   | 10d. Inside City Limits   |
| ith the Marylar<br>or 28e-f show<br>or notified at   | Md. Harford   | Abingdon  | 1 ☐ Yes ¾☐ No   |
| 5<br>sitar death with the Ma<br>in term 23a or 23e-1 s<br>riner must be notified<br>Funeral Director   | 10e. Street end Number<br>223 High Meadow Terrace   | 101. Zip Code<br>21009  | 10g. Citizen of What Country?<br>U.S.A.   |
| d 21215-0036 illed within 72 hours after death with the Maryland Hygiene. ther than *nature!; or itema 23a or 23a-1 show ent, the Medical Examiner must be notified at a Completed by Funeral Director   | 11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: | in U,S.  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I  1 □ Yes 2√2 No Specify:  | cify Yes or No-<br>Rican, etc.)  14. Race - American Indian,<br>Black, White, etc.  Specify: White          |
| 15-003<br>72 hours<br>"neturel;<br>after Exe   | 15. Decedent's Education<br>(Specify only highest grede completed)  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   | ng 16b. Kind of Business/Industry   |
| I 21215-003( led within 72 hours a lygiene. The Then "naturel", on the Medical Examint, the Medical Examint.   | Elementery/Secondary (0-12) College (1-4or 5+) 3 years  | ine. DO NOT use retired)  | city school system  |
| ind 2<br>be filed<br>d other<br>event, the   | 17. Fether's Neme (First, Middle, Last)   | 18. Mother's Name   | (First, Middle, Maiden Sumame)  |
| ylar<br>Suid be<br>Menta<br>Menta<br>ertic ev  | James Vitak   | Anna (unk   | known) Vitak  |
| Mary<br>nd 2 sho<br>lith and 1<br>27 le me<br>r treume   | 19a. Informant's Name/Relationship (Type, Print) Gloria Hillebrand/daughter   | 19b. Mailing Address (Street and Number or Rura<br>936 Imperial Court, Ba   | Route Number, City or Town, State, Zip Code)<br>altimore, Md. 21227   |
| Baltimore, Maryland 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or eny injury or other treumatic event, the Medical Examples.  To Be Completed by F   | t During a Competion of Domewolfrom State   | Db. Place of Disposition (Name of cemetery, crematory or other place)  Ost Holy Redeemer Cem. 12  | Date 20c. Location · City or Town, State 2/27/05 Baltimore, Md.   |
| Balti pemit. Departr Importa eny inju  | 21. Signature of Funeral Service Licensee   |   | Home of Bel Air, Inc.<br>ad, Bel Air, Md. 21014   |
|  | 23a Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.   | death. Do not enter the mode of dying, such as cardiac o  | r respiratory arrest, Approximate Interval Between  |
| Physician<br>/Medical<br>Examiner  | Immediate Ceuse (Final disease or condition resulting in death)   | OKIA  | Onset and Death  3 DAYS   |
|  | Due   | to (or as e consequence of):  |   |
| 68760,<br>ficata be executed<br>physician and<br>s the burial-transit  | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.  | to (or es a consequence of):  |   |
|  | that initiated events resulting in death) Last  | to (or as e consequence of):  |   |
| death certification of for use a siciary.  | d   |   |   |
| O. lo de he de /the a  | Part II. Other significant conditions contributing to death but not   | t resulting in the underlying cause given in Part I.  | 23b. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown             |
| y P deta   | ALZHEIMERS DEMENT   | 7A  | 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown   |
| al Records, P.O. Box ( The law requires that the death certificate has been signed by the attending to page 2 should be detached for use a Completed by Physician/M.   |   |   | 24a. Was en autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death? |
| Som Som  |   |   | 1 Yes 2 No 1 Yes 2 No   |
| Vital Recompositions of the law and a second of the la | 25. Was case referred to medical examiner?  | 26. Place of Death  | (Check only one)  |
| of Vital of Vital Physicien: this cartifical director.   |   |   | ne 5 ☐ Residence 6 ☐ Other (Specify)  |
| dlng P   | 27. Menner of Death  1 Adatural  2 Accident  28a. Dete of Injury (Month, Dey Yea  | ar) 28b. Time of lnjury 28c. Injury at Work?  M 1 □ Yes 2 □ No  |   |
| DIVISION TO Attendant of the by the deal of the by the central of the centra | a Could not be  |   | 28f. Location (Street and Number or Rura   Route Number,<br>City or Town, State)                            |
| Division of Vital Re To the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, page Medical Certification: To Be Com  | 29a. Certifier (Check only one)  Certifying Physician: To the best of my one)  Certifying Physician: To the best of my one one one one one one one one one one              | knowledge, death occurred at the time, date end place, emination end/or investigation, in my opinion, death occurred  | and due to the cause(s) and manner as stated.<br>and et the time, date and place, end due to the cause(s)   |
| To the vithin To the comple  | 29b. Signature and title of certifier   | 29c. License number   | 29d. Date signed (Month, Day, Year)   |
|  | MABhyankan A  | ND D25027   | DECEMBER 27, 2015   |
| 3  | 30. Name end eddress of person who completed cause of death   | (Item 23e) (Type, Print)  2 NORTH AVENUE  | DECEMBER 27, 2015<br>BEL AR MD 21014  |
| State<br>Registrar   | 31. Dete filed (Month, Day, Year)  32. Registrer's S  | Signature   |   |

ORIGINAL

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1.8 perMD.FH.G850.12.29.05 TI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) Gladys M. Kruszynski 2. Date of Death 3. Time of Death **Physician** Month Day Year 7:30 DECEMBER 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lombard Street Balhmore E. 8. Date of Birth (Month, Day, Year) 1915 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 DF Months Days Hours Min. 89 214-03-7494 Director Yrs. December 24 200 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic avant, it e Medical Examiner must be notified at 1 Yes 2 No Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Street "natural", or Itams 23a 4322 -ombard 21224 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If itam 27 is marked othar than "natural", or Itar Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify Completed by 3 Nidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Castodian 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be G1. 1 bert Drough ton 2 19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 4322 E. Lombak itam 27 i Me Daughte altimore m 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of I Important: If its any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State <sup>4</sup> □ Donation 5 □ Other (Specify) Cemekky LAWN 22. Name and Address or Facility 21. Signatur et Forierai Service Licential Funeral Drad 1e4toN MO1455 DriNG Willow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** SEPSIS 4 DAYS /Medical Due to (or as a consequence of) Examiner URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ig physician and as the burial-transit the Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 Other (specify) P.O. I the 9 Unknown Š signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 🔼 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М Diractor: in 24 hour.
the Funaral Dirac. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 21 00062032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYVIEW CIRCLE, BALTIMORE 5505 HOPKINS JENNIFER HAYASHI, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 9 2005 Registrar

|  |                      | 1 - For State Registrar   | State of M  |                                       |  | ent of F                                      |  | d Mental Hyg                                    | iene<br>•g. No2 0 0 5                         | 42091   |  |  |
|--|----------------------|---|---|---------------------------------------|--|---|--|---|---|---|--|--|
| Physic<br>/Med<br>Exami  | cal                  | 4a. Facility Name (If not institution, given  | re street and number  |                                       | 4b. (                                      | City, Town, o                                 | r Location of De                               |   | DayNO Year<br>22, 2005<br>4c. County of De.   | 12.50°M   |  |  |
| Funeral<br>Director  |                      | 5. Social Security Number 6.  | thwest Hospita<br>Sex 7. A<br>1 M 2 X F                                 | ge (In yrs. last birtl                | nday) If U                                 | nder 1 Year<br>ths Days                       | Rar  | in. (Month, Day                                 | Year) 9. Bi                                   | altimore  rthplace (State or Foreige Country)                       |  |  |
|  |                      | Usual Residence of Decedent 10a. State 10b. County  | ltimore   | 10c. City, Town                       | or Location                                | Rai   | ndallstown                                     | War 20  | ), 1916                                       | So. Carolina  10d. Inside City Limits 1 🛱 Yes 2 🗆 No                |  |  |
| th with the<br>23e or 28   | al Director          | 10e. Street and Number<br>9023 Bruno Road   |   |                                       | 10f  | . Zip Code                                    | 21133  | 1   | 0g. Citizen of What C                         | S.A.  |  |  |
| within 72 hours after deeth with the Maryland within 72 hours after deeth with the Maryland one. then "natural, or iteme 23e or 28e-f ehow he Medical Examiner must be notified at   | Completed by Funeral | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates         | KNO                                   |  | ecedent of H<br>specify Cuba<br>es 2 (1) (Nio | ispanic Origin?<br>In, Mexican, Pu<br>Specify: | (Specify Yes or No-<br>erto Rican, etc.)        |   | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: Black |  |  |
| ges 1 and 2 should be filed within 72 hours aft to Health and Mentel Hyglene. If item 27 is marked other then "natural", or or other traumatic event, the Medical Exami  | Completed            | 15. Decedent's E<br>(Specify only highest gr.<br>Elementary/Secondary (0-12)  | ade completed) College (1-4or   |                                       | Decedent's l<br>Give kind o<br>life. DO NO |   | ation<br>during most of w<br>nemaker           | vorking   | 16b. Kind of Business                         | Mome  |  |  |
| Viai yiailiu z iz iz iz iz should be filed within h and Menlel Hyglene. 7 is marked other then "traumatic event, traumatic   | To Be                |   | Ross  |                                       |  |   |  |   | za Wood                                       |   |  |  |
| I and 2 sh<br>tealth and<br>im 27 is m   |                      | Janelle Langott   | Турв, Print)  |                                       | 9023                                       | Bruno Ro                                      |  | llstown, Maryla                                 |   |   |  |  |
| L Parit  |                      | 20a. Method of Disposition  1 Method of Disposition  1 Method of Disposition  3 Communication    4 Donation    5 Other (Special   | (y)   | ,                                     | crematory King Me                          | or other place<br>emorial P                   | ark  | 12/29/05  | 20c. Location - City o                        | r Town, State  r Mill, Md.  |  |  |
| permit. Depertrimportu   |                      | 21. Signature of Funeral Service Lice   | Esta  | P                                     |  |   |  |   |   |   |  |  |
| Physician   Physic | dicai Examiner       | 23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last | a   |                                       | (C) (A)                                    |   | EWE F  |   | yst,  | Approximate<br>Interval Between<br>Onset and Death                  |  |  |
| the deeth certifully that ettending the  | Physician/Med        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknowh  | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 Fetal death                         | 3 Ectopi                                   | ic pregnancy<br>(specify)                     |  | 23d. Date of de<br>Month                        | livery<br>Day Year                            |   |  |  |
| w requires that been signed by should be data  | þ                    | Part II. Other significant conditions of  | ontributing to death I  | but not resulting in t                | he underlyir                               | ng cause give                                 | en in Part I.                                  |   | acco use contribute to                        | the cause of death?   |  |  |
|  | Completed            |   |   |                                       |  |   | 1.1  | 24a. Was ar<br>autops<br>perform<br>1 □ Yes 2   | / prior to                                    | utopsy findings available completion of cause of                    |  |  |
| Physician:<br>this certific<br>ral director,   | Be                   | 25. Was case referred to medical examiner?  | Hospital:   |                                       |  | DOA Othe                                      | · C  | eath Check only one                             | 4   |   |  |  |
| Ing<br>Afte  | ation: To            | 1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Inju<br>(Month, Da   | ury 28b. Tir                          | ne of                                      | 28c. Injury<br>Work                           | 4   Nursing                                    | Home 5 Reside                                   | nce 6 Other (Spe<br>w injury occurred         | cify)   |  |  |
| tal or Attending<br>is efter death.<br>el Director: Afte<br>ed in by the fune  | Certification:       | 3 Suicide 6 Could not b   | 28e. Place of in  | jury - At home, farn<br>tc. (Specify) | n, street, fac                             | story, office                                 |  | 28f. Location (Str<br>City or Town              | eet and Number or R<br>, State)               | ural Route Number.  |  |  |
| o the Hospital or At<br>ithin 24 hours eftar o<br>o the Funarel Direct<br>impletely filled in by   | edical               | 29a. Certifying Ph<br>(Check only one) 1 Certifying Ph<br>2 Medical Exam  | ysician: To the best<br>niner: On the basis of<br>and manner st         | or examination and/                   | death occurr<br>or investigat              | red at the tim<br>tion, in my op              | e, date and place<br>inion, death occ          | ce, and due to the ca<br>curred at the time, da | use(s) and manner as<br>te and place, and due | s stated.<br>to the cause(s)  |  |  |
| To the lawithin 2. To the lacemplet  | ×                    | 29b. Signature and title of certifier   | melta   |                                       |  |   | 410  | D   | ed. Date signed (Mont                         | th. Day, Year)  |  |  |
| 7  |                      | 30. Name and ad a ess of person who 31. Date filed (Month, Day, Year)   | MASTATE   | CENTE                                 | /pe, Print)                                | JOGINI  | OCT II   | MEHTA   | 2433  |   |  |  |
| Sta<br>Regist  |                      | NFC 2 9 2005  | 32. Registi   | rar's Signature                       |  |   |  |   |   | 1   |  |  |

|             |   |                 | 1 - For<br>State<br>Ragistrar   | State of Marylan   | -                                | artment of H<br>rtificate of   |                                      |  | giene<br>Reg. No. 2 (               | 005 4209   |
|-------------|---|-----------------|---|--|----------------------------------|--|--------------------------------------|--|-------------------------------------|--|
|             | Physici<br>/Medic   |                 | 1. Decedent's Name (First, Middle, Las<br>Hilda Barbara Li  | •  |                                  |  |                                      | 2. Date of De<br>Month                     | Day Day                             | Year 2005 4:10 P M   |
|             | Examir<br>Funeral<br>Director   |                 | 210 20 1101   | sing Home  | last birthday)<br>Yrs.           | HOVIE  If Under 1 Year  Months Days                                  | If Under 24 H                        | CCC<br>rs. 8. Date of Birt                 | y, Year)                            | 9. Birthplace (State or Foreign<br>Country)<br>Pennsylvania            |
|             | aryland<br>show   | <u>_</u>        | Usual Residence of Decedent  10a. State 10b. County   |  | y, Town or Lo                    |  | le Grace                             |  |                                     | 10d. Inside City Limits 1   Yes 2 □ No                                 |
|             | with the M<br>s or 28e-f<br>be notified   | Director        | Md. Harford  10e Street and Number  415 S. Market St  |  |                                  | 10f. Zip Code  | 21078                                |  | 10g. Citizen of V                   | What Country?  |
| 36          | ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "netural; or Items 23e or 28e-f show or other traumatic event, the Mudical Exertifyer must be incitified at | by Funerai      | 11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:   | 1                                | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yas 2 H No           |                                      | (Specify Yes or No<br>erto Rican, etc.)    | 14. Rac<br>Blac                     | ce - American Indian,<br>ck, White, etc.<br>v: White                   |
| 21215-0036  | s within 72 hou<br>piene.<br>r than "neture<br>the Medical E  | Completed       | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>8 years  |  | 16a. Dece<br>(Give<br>life.      | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>aker | pation<br>during most of v<br>d)     | vorking                                    |                                     | usiness/Industry home  |
| Maryland 2  | 2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M  | To Be C         | 17. Father's Name (First, Middle, Last) Matthew Wiherle   |  |                                  |  |                                      | ame <i>(First, Middle,</i><br>ra Skoff     | Maiden Suman                        | ne)  |
|             | and 2 sho<br>leaith and<br>m 27 is my<br>her traum  |                 | 19a. Informant's Name/Relationship (7<br>Anthony Libonate   | e/son  | 507                              | F Cider I  |                                      | ad, Joppa                                  |                                     | ·  |
| Baltimore,  | Pa<br>Int   |                 | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify   | Removal from State Sa  | cred H                           | sition (Name of<br>natory or other place<br>eart of                  | Jesus 12                             | Date 2/30/05                               | Dundalk                             | City or Town, State  |
| Bal         | permit. Pa<br>Departmer<br>Important:<br>any Injury<br>once.  |                 | 21. Signature of Funeral Service Licen  Buch C. L   | vellen   | S 6                              | 10 W. Ma   | Funeral<br>Phail F                   | Home of                                    | Air, Md                             | 1. 21014   |
| 8760,       | hysician and hysician and the buriaritansit   | dicai Examiner  | 23a. Part1. Enter the disease, or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a ue to (or as a consequence to be ue to (or as a consequence consequence) ue to (or as a consequence consequenc | uence of):                       | arten  | withs                                | ellar                                      | liza.                               | Approximate Interval Between Onset and Death                           |
| O. Box 68   | death certific<br>e attending p<br>id for use as  | Physician/Medio | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown   | 23c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown   | Ideath 3                         | Ectopic pregnancy  | /                                    |  | 23d. Dat<br>Mor                     | te of delivery<br>nth Day Year   |
| ords, P.    | sign<br>sign<br>d be  | by              | Part II. Other significant conditions co  | ontributing to death but not resu  | ulting in the u                  | nderlying cause giv  | ren in Part I.                       | 23e. Did to                                | - L                                 | ribute to the cause of death?  3 Probably 4 Unknown                    |
| Il Records, | The<br>ate h<br>page  | Completed       |   |  |                                  |  |                                      | 24a. Was autop<br>perfor<br>1 \sum Yes     | sy p<br>męd? d                      | Were autopsy findings available prior to completion of cause of death? |
| Vital       | Physician: Th<br>this certificate<br>ral director, pag  | Be              | 25. Was case referred to medical examiner?  | Hospital:  |                                  | . aC pos Cth   | er \                                 | eath (Check only o                         |                                     |  |
| of          |   | on: To          | 27. Manner of Death  1 Natural 5 Pending  | 1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)   | 28b. Time of<br>Injury           | t 3 DOA 28c. Injur   | 4 Mursing                            | Home 5 Resid                               |                                     |  |
| Division    | or Attention ter deal irector:  | Certification;  | 2 Accident investigation 3 Suicide 6 Could not be determined  |  | ome, farm, str                   |  | Yes 2 □ No                           | 28f. Location (5<br>City or Tow            | treet and Numbe<br>n, State)        | er or Rural Route Number,  |
| -           | Hospita<br>24 hours<br>Funeral  | edical C        | 29a. Certifier 1 Certifying Phyone) 1 Medical Example 1   | ysician: To the best of my kno<br>linar: On the basis of examinal<br>and manner stated.  | wledge, death<br>tion and/or inv | occurred at the tir<br>restigation, in my o                          | ne, date and pla<br>pinion, death oc | ce, and due to the courred at the time, of | ause(s) and ma<br>late and place, a | unner as stated.<br>and due to the cause(s)                            |
| 10          | To the within 2 To the complete   | Me              | 29b. Signature and title of certifier  30. Name a laddres of person who certifier   | e MrD. completed cause of death (Item , 669 Revoluti   | 1 23a) (Type,                    | 29c. Licens Print) Havre   | 206                                  | 6/   | 13                                  | (Month, Day, Year)   |
|             | Sta<br>Registr  |                 | J. T. Lee, M.D.  31. Date filed (Month, Day, Year)  DFC 2 9   | 32. Registrar's Signa  |                                  | Annal e  |                                      |  |                                     |  |

DHMH 17 Rev 1/2001

Liborate, Hilda B.

|  |                  | State of Maryland / Dep   |  | -                                    | -   |
|--|------------------|---|--|--------------------------------------|---|
|  |                  | _ FOI   | rtificate of Death   |                                      | 2005 42096  |
| Physic   | ian              | 1. Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month            | Day Year 3. Time of Death   |
| /Med   | ical             | Roxie Irene Leonardi  4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death   | Dec 24                               | 4c. County of Death   |
| Exami  | nér              | 1111 N. Marlyn Ave.   | Essex  |                                      | Baltimore   |
| Funeral  |                  | Social Security Number     6. Sex     7. Age (In yrs. last birthday)  |  | 8. Date of Birth<br>(Month, Day, Y   | 9. Birthplace (State or Foreign Country)                                |
| Director   |                  | 218-40-1889 1 M 3CMF 64 Yrs.  |  | Nov.19,                              | 1941 MAryland   |
| yland  |                  | 10a. State 10b. County 10c. City, Town or L   | ocation  |                                      | 10d. Inside City Limits   |
| Ba-fal   | ctor             | MD Baltimore Ess  |  |                                      | 1 ☐ Yes 2 📆 No  |
| with the   | Funeral Director | 1111 N MArlyn Ave.  | 10f. Zip Code<br>21221   |                                      | g. Citizen of What Country?<br>USA                                      |
| death<br>ms 23   | Jera             | <del>_</del>  | . Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puert |                                      | 14. Race - American Indian,<br>Black, White, etc.                       |
| or Ite   | y Fu             | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No  | 1 ☐ Yes 2☐ No Specify:   | o rriodri, etc.)                     | Specify:White   |
| be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f ahow event, the Modical Enarthrap reset by ricitified at  | ed by            | 15. Decedent's Education 16a. Dece  | edent's Usual Occupation   | 16                                   | Sb. Kind of Business/Industry   |
| thin 72  | Completed        | life.   | e kind of work done during most of wor<br>DO NOT use retired)<br>⊇maker        |                                      | own home  |
| iled will tygien her th  |                  | 10th<br>17. Father's Name (First, Middle, Last)   |  | ne (First, Middle, Ma                |   |
| d be fi  | o Be             | William A. Carson   |  | ret Bold                             | i i   |
| IDIC, INICITY CALL IN TOUCOUNTY STATES THE MANY SET 1 and 2 should be filed within 72 hours after death with the Manyle tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 ahou or other traumatic event, the Modical Evantrial must be notified.   | -                | 19a. Informant's Name/Relationship (Type, Print) 19b. Mail  | ling Address (Street and Number or Ru  | ral Route Number, (                  | City or Town, State, Zip Code)  |
| and 27 Imm 27 Im |                  |   | 11 N.Marlyn Ave  |                                      | nore MD 21221  oc. Location - City or Town, State                       |
| Pages 1<br>nent of H<br>nnt: If its  |                  | 20a. Method of Disposition  1 □ Burial 2 ত Cremation 3 □ Removal from State  1 □ Donation 5 □ Other (Specify)   | position (Name of permatory or other place) vCrematory 12/                     | 10                                   | altimore MD   |
| J 2 2 2 3  |                  |   | 22. Name and Address of Facility   | nnellvFu                             | neralHomeofEssex  |
| permi<br>Depai<br>Impo   |                  | 1. Jerry Connelly   | 300 Mace Ave   | . Baltim                             | ore MD 21221  |
|  |                  | 23a. Part.1. Enter the disease, or completitions that caused the death. To not en shock, or heart failure. List any one cause on each line.  Immediate Cause (Final |  |                                      | Interval Between  |
| Physician<br>/Medical  | _                | disease or condition resulting in death)  Due to (or as a consequence of):  | ro vascular  | TILL                                 | rem ruk-  |
| Examiner   | ١.               | Sequentially list conditions b.   |  |                                      |   |
| ed   | Examiner         | Sequentially list conditions, I any, leading to firm solution cause. Enter Underlying Cause (Disease or injury that initiated events  c                             |  |                                      |   |
| rou, te be executed ysician and e burial-transit   | Exan             | that initiated events c. Due to (or as a consequence of):   |  |                                      |   |
| w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit.   | cal              | d   |  |                                      |   |
| The taw requires that the death certifical the has been signed by the attending phoage 2 should be detached for use as the   | Physician/Med    | IF FEMALE: 23c. If yes, outcome of pregnancy  |  |                                      | 23d. Date of delivery   |
| death death death death death  | ician            | 2.30. Was decedent pregnant in the past 12 months?  1 \[ \text{Live birth} \ 2 \] \[ \text{Fetal death} \ 3 \]  1 \[ \text{Vas} \ 2 \] \[ \text{Na} \]              | ☐ Ectopic pregnancy ☐ Other (specify)  |                                      | Month Day Year  |
| at the   | Phys             | 9 □ Unknown   |  | CO. Didasha                          |   |
| signed to be do  | b                | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part I.  | 23e. Did toba                        | cco use contribute to the cause of death?  2-☐No 3☐ Probably 4 ☐Unknown |
| w requires<br>been sign  | Completed        | 30,8  |  | 24a. Was an                          | 24b. Were autopsy findings available                                    |
| On Of VItal Red<br>ding Physician: The lav<br>h.<br>After this certificate has<br>funeral director, page 2   | dmo              |   |  | autopsy performe                     | prior to completion of cause of death?  No 1 Yes 2 No                   |
| VITAI<br>ician: I<br>certifical<br>ector, p  | Be               | 25. Was case referred to medical examiner?  |  | th (Check only one)                  |   |
| Of VILA Phyaician: r this certific ral director,   | P.               | 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie<br>27. Manner eath 28a. Date of Injury 28b. Time  |  | ome 5 esiden<br>28d. Describe how    | ce 6 Other (Specify)  |
| Attending r death.  ector: After by the fune   | atlon            | 1 — atural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation  |  |                                      |   |
| LIVISION  or Attending after death. Director: Afte   | Certification:   | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined building, etc. (Specify)  | street, factory, office  | 28f. Location (Stre<br>City or Town, | et and Number or Rural Route Number,<br>State)                          |
| pital o  |                  | 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, dea   | ath occurred at the time, date and place                                       | and due to the cau                   | se(s) and manner as stated  |
| To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | Medical          | ((Check only one) 2 Medical Examiner: On the basis of examination and/or i and manner stated.   |  |                                      |   |
| To th<br>withir<br>To th<br>comp   | Me               | 29b. Signature and title of certifier   | 29c. License number  | 290                                  | 1. Date signed (Month, Day, Year)                                       |
| a  |                  | P (V)   | Wids   | HA                                   | HILLAND   |
| 5  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type  | saltimuse  | MI                                   | 31351   |
|  | tate             | 31. Date filed (Month, Day, Year)  32. Registrar's Signature  |  | 1                                    |   |
| Regis  | trar             | SEO O ZUUS STREET ST. ST.   |  |                                      |   |

DHMH 17 Rev 1/2001

**ORIGINAL** 

|                                     | 1 - State<br>Registrar   |  |                                   |   | Certificate of   | Dealli                       |                    | Reg. No.          | XUUJ                | 72091   |
|-------------------------------------|--|--|-----------------------------------|---|--|------------------------------|--------------------|-------------------|---------------------|---|
| hysician                            |  | ne (First, Middle, La                    | nsiquotad                         | oon                                     |  |                              | 2. Date of De.     | ath / — ]         | 3-2005              | 3. Time of Death 10: 45AM                       |
| /Medical                            |  |  | ve street and number)             | - Teen                                  | 4h City Town o   | r Location of Death          |                    | 40.0              | ounty of Death      | 10.43/1   |
| xaminer                             |  | ross Ho                                  |                                   |   | Silver   |                              | •                  |                   | tgomer              | v   |
| eral                                | 5. Social Security N   |  |                                   | (In yrs. last birt                      | nday) If Under 1 Year  | If Under 24 Hrs.             | 8. Date of Birt    | th.               | 9. Birthp           | place (State or Foreign                         |
| tor                                 | None   | e  | 1 □ M 2 🖫 F                       | ١                                       | rs. Months Days  | Hours Min.                   | 07/03              | $\frac{y_1}{200}$ | 5 Mary              | land  |
|                                     | Usual Residence o  | of Decedent<br>10b. County               |                                   | 10c. City, Town                         | or Location  |                              |                    |                   | 1                   | 0d. Inside City Limits                          |
| 5                                   | Toa. State   | TOD. County                              |                                   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | roix, Vir  | ain Isl                      | ands               |                   |                     | 1 ☐ Yes 2 🔯 No                                  |
| To Be Completed by Funeral Director | 10e. Street and Nu   | ımber                                    |                                   | 500                                     | 10f. Zip Code  | 91 101                       |                    | 10a, Citize       | on of What Cour     | ntry?   |
|                                     |  |  | incess Hi                         | 11                                      |  |                              |                    | U                 |                     | ,   |
| nera                                | 11. Marital Status   |  | 12. Was Decedent 8                |   | 13. Was Decedent of H  | Hispanic Origin? (S          | pecify Yes or No   | - 14              | Race - Americ       |   |
| E.                                  | 1XX Never Man  | ried 2 Married                           | 1 Yes 2X N                        | lo                                      | 1 ☐ Yes 2 No   | Specify:                     | o moan, etc.)      |                   | Black, White,       |   |
| d by                                | 3 Widowed  | 4 Divorced                               | Year or Dates:                    |   |  |                              |                    |                   | Specify: Bla        |   |
| ete                                 | (Spe   | 15. Decedent's E<br>cify only highest gr | ducation<br>ade completed)        | 16a.                                    | Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retire | pation<br>during most of wor | king               | 16b. Kind         | d of Business/Inc   | dustry  |
| Completed                           | Elementary/Sec   | ondary (0-12)<br>/A                      | College (1-4or 5                  | +)                                      | N/A  | -,                           |                    |                   | N/A                 |   |
| Be Co                               |  | (First, Middle, Las                      | ()                                |   |  | 18. Mother's Nan             | ne (First, Middle, | Maiden S          | umame)              |   |
| To B                                | Yusuf  | Jamal A                                  | deen/Fath                         | er                                      |  | Chris                        | Lansiq             | uota              | deen                |   |
|                                     | 19a. Informant's N   | lame/Relationship                        | (Type, Print)                     | 19b.                                    | Mailing Address (Street  | and Number or Ru             | ral Route Numbe    | er, City or       | Town, State, Zip    | Code)   |
|                                     | Yusuf  | Jamal A                                  | deen                              |   | 68 Little  | Prince                       |                    | 1, S              | t.Croi              | x, VI   |
|                                     | 20a. Method of Dis   |  | ☐Removal from State               | 20b. Place of<br>cemeter                | Disposition (Name of<br>v, crematory or other place                          | ce)                          | Date               | 20c. Loca         | ation - City or To  | own, State                                      |
|                                     | `4 □ Donation  | 5 ☑ Other (Speci                         | in state                          |   |  | į                            |                    |                   |                     |   |
| once.                               | 21. Signature of F   | uneral ervice Lice                       | Wade Dir                          | Logo                                    | 22. Name and Addre   | omy Board                    | 655 W.             | Bal.t             | imore S             | treet   |
|                                     | OZO PORT FOTOS   | the disease of one                       | 7-/ COO                           | the death. Do o                         | Baltimore, ot enter the mode of dyir   |                              |                    | root              |                     | Approximate                                     |
|                                     | shock or hea   | art failure. List only                   | one cause on each lin             | 10.                                     |  |                              |                    |                   |                     | Interval Between<br>Onset and Death             |
| ian<br>cal                          | disease or conditi-<br>resulting in death)   | ion                                      | _ a                               | a consequence of                        | f membran  | es prio                      | 1 00 1             | abor              |                     |   |
| ner                                 |  |  |                                   | eterm                                   | .,.  |                              |                    |                   |                     |   |
| Jer                                 | Sequentially list co<br>if any, leading to it<br>cause. Enter Und<br>Cause (Disease of | onditions,<br>mmediate                   | Due to (or as                     | a consequence o                         | f):  | <del> </del>                 |                    |                   | -                   |   |
| Examiner                            | that initiated event   | (S                                       | C                                 |   |  |                              |                    |                   |                     |   |
|                                     | resulting in death)  | Last                                     | Due to (or as                     | a consequence o                         | f):  |                              |                    |                   |                     |   |
| dica                                |  | •  | d                                 |   |  |                              |                    | _                 |                     |   |
| /Me                                 | IF FEMALE:   |  | 23c. If yes, outcome              | of pregnancy                            |  |                              |                    | 23                | d. Date of delive   | 201   |
| cian                                | in the past 12   | 2 months?                                | 1□Live birth<br>4□Pregnant at     | 2 Fetal death                           | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _                                  | у                            |                    |                   | Month               | Day Year  |
| Physician/Medical                   | 1 Tes 2  |  | 9□ Unknown                        |   |  |                              |                    |                   |                     |   |
| by Pl                               | Part II. Other sign  | ificant conditions                       | contributing to death be          | ut not resulting in                     | the underlying cause give  | ven in Part I.               | 23e. Did t         | obacco use        | e contribute to the | ne cause of death?                              |
|                                     |  |  |                                   |   |  |                              | 1 🗆 `              | Yes 🎾             | No 3☐Prob           | ably 4 Unknown                                  |
| Completed                           |  |  |                                   |   |  |                              | 24a. Was           |                   | 24b. Were auto      | psy findings available<br>impletion of cause of |
| Com                                 |  |  |                                   |   |  |                              | perfo              | rmed?             | death?              | 2 <del>√</del> 2 No                             |
| Be (                                | 25. Was case refe  | erred to medical                         |                                   |   |  |                              | ith (Check only o  | опе)              |                     |   |
| 2                                   | 1 ☐ Yes 2 ∑  |  | Hospital:                         |   | patient 3 DOA  |                              | lome 5 Resid       |                   |                     | y)  |
| on:                                 | <ol> <li>Manner of Dea</li> <li>Natural</li> </ol>                                     | 5 Pending                                | 28a. Date of Injui<br>(Month, Day | y Year) 28b. T                          | njury Wor  | rk?                          | 28d. Describe I    | how injury        | occurred            |   |
| Certification:                      | 2 Accident 3 Suicide   | investigation 6 Could not                | be Ose Blees of Isia              | uny - At home, fai                      |  | Yes 2⊠No                     | 28f Location (     | Street and        | Number or Bura      | d Route Number,                                 |
| , jii                               | 4  Homicide  | determine                                | building, etc                     | c. (Specify)                            | m, street, factory, office   |                              | City or To         |                   | Number of Aura      | ir noute Number,                                |
| 2                                   | 29a, Certifier   | 1 Certifying P                           | hysician: To the best             | of my knowledge                         | , death occurred at the til  | me, date and place           | , and due to the   | cause(s) a        | nd manner as s      | tated.  |
| Medical Certifi                     | (Check only one)   |  |                                   | examination and                         | 1/or investigation, in my  |                              |                    |                   |                     |   |
| Me                                  | 29b. Signature and   | d title of certifier                     | 1 04.0                            |   | 29c. Licens  |                              |                    | 29d. Date         | signed (Month,      | Day, Year)                                      |
|                                     | 14   | jan (                                    | MUGNYE                            | ~ bu                                    | 1) AH ?  | 23281                        | 15                 | 8                 | 5/05                |   |
|                                     | - 1/   |  |                                   |   |  |                              |                    |                   | -                   |   |
|                                     | 30. Name and add   | dress of person who                      | completed cause of d              | eath (Item 23a) (                       | Type, Print)   |                              |                    |                   |                     |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 7.8 10e per ft. 9851 1-10-06 vt.
State of Maryland Department of Health and Mental Hygiene Communication. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Marguerite A. Lee December 7:30AM 19 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Baltimore city If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Oay, 7 3 1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 M 2 T -80-77 Yrs. 218-26-7932 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No N/A Balto 10e. St**7928** Number 10f. Zip Code 10g. Citizen of What Country? 7028 Dunhill Village Circle Apt 201 21244 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 XWidowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Elementary/Secondary (0-12) 12th grade Post Office Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Garfield Goldring Marie Ballard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Foster - Son Michael 7914 Dunhill Village Circle Apt 102 Balto, Md 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State King Memorial Park 12-23-2005 Randallstown, Md 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Linense 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic heart disease disease or condition resulting in death) Due to (or as a consequence of) Mrocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 D No 1 ✓ Inpatient 2 ☐ ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending м 1 TYes 2 TNo 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Physician /Medical Examiner be executed burial-transit Division of Vital Records, P.O. Box 68760 attending physician use as the ò Physic detached by Completed Hospitel or Attending Physician: funeral director. 2 Si Li Certification: After within 24 hours after death. To the Funeral Director: A filled in by the

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ပ

Examiner

ician/Medical

IF FEMALE:

10a. State

Md

**Funeral** 

Director

item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at

nit. Pages 1 and 2 should be filed within 72 hours after tarment of Health and Mental Hygiene.
ortent: If item 27 is marked other than "natural", or Ite injury or other traumatic event, the Madical Exeminal.

permit. Page Department of Important: If any injury or

the Maryland

death

Maguerite LE1 Maryland 21215-0036

Baltimore,

completely State

To the

Alejando 31. Date filed (Month, Day, Year) Registrar DEC 2 9 2005

4 | Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

Sequeira 2435 West Belvedere Avenue Baltimore Marrland 21215

and manner stated

Deguerra MD.

30. Name and advers of person who / impleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/200

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO024726

29d. Date signed (Month, Day, Year)

December 19 2005

Registrar

DECEMBER

ELIZABETH

LOMBARDO,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER Day Year 24, 2005 Physician 7:35 PM PETER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Baltimore Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F May 8, 92 Yrs. Pennsylvania Director 215-10-0349 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be nutified at 1 ☐ Yes 2 No Directo Maryland Baltimore County Rodgers Forge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 214 Overbrook Road 21212 or Iteme 23a USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ₩ Widowed 4 Divorced natural 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Purchasing agent Manufacturing Company 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be flik Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Joseph Lipko Annie <u>Anotsky</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara M. Townsley (Daughter) 213 Coldbrook Road, T Timonium, MD 21093 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/30/2005 Parkwood Cemetery Parkville, Maryland 21. Signature of Funeral Service Line 1988 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a ASPIRATION FINEUMONIA **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and the for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE signed by the attendin d be detached for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 2LXNo 2No 1 Yes 1 🗌 Yes Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 5X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28d. Describe how intury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D 0025806 b 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M D 76 Ø 1 ( 32. Begistrar's Signature OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) State Registrar

|                |   |                | for<br>1 ← For<br>Registrar  | State of Maryland  |   | nt of Health<br>te of Death                   |   | lygiene<br>Reg. No.         | 005                             | 42101   |
|----------------|---|----------------|--|--|---|---|---|-----------------------------|---------------------------------|---|
| 1              | Physici   | an             | 1. Decedent's Name (First, Middle, La  | st)  |   | KIMO  | 2. Date of I  | Death<br>Day                |                                 | 3. Time of Death                                  |
| N-16.5         | /Medi   | cal            | 4a. Facility Name (If not institution, giv   | a street and number)   |   | y, Town, or Location                          | of Death  |                             | 24 200<br>County of Deat        | 15 3:13 AM  |
|                | Examir  | ier            | JOHNS HOPKIN   | S BAYVIEW HO   | SPITAL BF   | JLTIM!  | ORE   | 40.                         | County of Deat                  |   |
|                | - Funeral<br>Director   |                | 45.46.6006   | ex 7. Age (In yrs. las   | Yrs. If Undo  |   | Min. 8. Date of E                                   | Birth<br>Day, Year)         | Co                              | hplace (State or Foreign untry)                   |
|                | yland<br>yland  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City,   | Town or Location                                      |   |   |                             |                                 | 10d. Inside City Limits                           |
|                | Ba-fah  | Director       | MD HARFORT   | > 3  | L AIR   | •   |   |                             |                                 | 1 Yes 2 No  |
|                | with th   | Dire           | 10e. Street and Number   | n in -   | 10f. Z  | ip Code                                       |   |                             | zen of What Co                  | untry?  |
|                | death   | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in U.S.<br>Armed Forces?   | 13. Was Dec   | edent of Hispanic O                           | rigin? (Specify Yes or I                            |                             | 14. Race - Ame                  |   |
| 5-0036         | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or Itama 23e or 28e-f ahow or other traumatic event, the Medical Exemplar must be natified at | by             | 1 ☐ Never Married 2 ☐ Married<br>3 ☑ Widowed 4 ☐ Divorced  | 1 Yes 2 No If Yes, Give Year or Dates:   | 1 🗆 Yes   | /   | ,   |                             | Specify: White                  |   |
| 15-0           | "natu   | letec          | 15. Decedent's Ed<br>(Specify only highest gra   |  | 16a. Decedent's Us<br>(Give kind of w<br>life. DO NOT | ork done during mo                            | st of working                                       | 16b. Kir                    | nd of Business/                 | ndustry   |
| 2121           | filed within<br>Hygiene.<br>other than  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)   | MADN  | 3EL   |   |                             | DAREH                           | ause_   |
| Maryland       | Mental H<br>Mental H<br>arked oth   | Be             | 17. Father's Name (First, Middle, Last)  | MISKIN   | 104   |   | ner's Name (First, Midd                             | lle, Maiden                 | Sumame)                         |   |
| aryl           | 2 should<br>and Men<br>is marks<br>sumatic  | 2              | 19a. Informant's Name/Relationship (   |  |   | ss (Street and Numb                           | Der or Rural Route Num                              | nber, City or               | Town, State, 2                  | Tip Code) 21024                                   |
| -              | and 2<br>lealth a<br>m 27 is  |                | JEAN MARTIN  | SITTER   | 4055  | FEDERAL                                       | HILL RD   | JARR                        | EI ISULL                        | EMD   |
| Baltimore,     | Pages 1<br>nent of H<br>int: If ital  |                | 20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif   | Removal from State   | ce of Disposition (Na<br>netery, crematory or         | other place)                                  | 12 · 28 ·   | ~                           | cation - City or                | Fown, State                                       |
| altir          | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  | 1 8            | 21. Signature of Funeral Service Licer   | - I - AKCL   | 22. Name :  | LCHAPELI<br>and Address of Facil              | lity EUANS FU                                       | good<br>WER                 |                                 | EL BELAIR   |
| 8              | 80 E 8  |                | MDAK   | _ Moi220   | 310   | WPOR  | T DR. S   | rcess                       | I HILL                          | -, MD 2105C                                       |
|                | Physician   |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) |  | Do not enter the mo                                   | FAILU   | s cardiac or respiratory                            | arrest,                     |                                 | Approximate Interval Between Onset and Death HOUS |
| 7              | /Medical<br>Examiner  |                | Sequentially list conditions,  | Due to (or as a consequent SEPSIS  | nce of):  |   |   |                             |                                 | 5 days  |
|                | pe isit   | Juner          | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a consequer  | nce of):  |   |   |                             |                                 | to days   |
| 8760,          | cate be executed<br>physicien and<br>the burial-transit   | al Examiner    | that initiated events<br>resulting in death) Last  | Due to (or as a consequen  | nce of):  |   |   | -                           |                                 | oaugs   |
| 687            | phy:  | edical         |  | d  |   |   |   |                             |                                 |   |
| P.O. Box       | The law requires that the death certific<br>ete has been signed by the attending p<br>page 2 should be detached for use as  | Physician/Me   | JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome of pregnanc<br>1 □ Live birth 2 □ Fetal de<br>4 □ Pregnant at time of deat<br>9 □ Unknown | eath 3 Ectopic  |   |   | . 2                         | 23d. Date of deli<br>Month      | very<br>Day Year                                  |
| Θ,             | uires that the de<br>signed by the a<br>Id be detached f  | by Ph          | Part II. Other significant conditions of   | ontributing to death but not resulti   | ng in the underlying                                  | cause given in Part                           | I. 23e. Dio   | d tobacco u                 | se contribute to                | the cause of death?                               |
| ord            | w require<br>been sig<br>should b   | ted k          | HEPATIC CI   | RRHOSIS  |   |   | 10  | ]Yes 2 ⊅                    | ŽNO 3□Pro                       | obably 4 Unknown                                  |
| Vital Records, | The law rate has be page 2 sh   | Completed      |  |  |   |   | 24a. We auf per 1 Tyes                              | topsy<br>rformed?           | prior to death?                 | topsy findings available ompletion of cause of    |
| Vita           | yeician: Th<br>is certificate<br>director, pag  | Be             | 25. Was case referred to medical examiner?   | Hospital: 🔀:   |   | Other   | e of Death (Check only                              |                             |                                 |   |
| ō              | ding Phye   | n: To          | 1 ☐ Yes 2 No  27. Manner of Death  | 28a. Date of Injury 2  | NOutpatient 3 0<br>8b. Time of                        | 28c. Injury at Work?                          | ursing Home 5 ☐ Re<br>28d. Describe                 |                             |                                 | ify)  |
| sion           | ending<br>eath.<br>or: Afte<br>the fun  | atlo           | 1 Natural 5 Pending 2 Accident investigation   | I I  | Injury<br>M   | Work?<br>1 ☐ Yes 2 ☐                          | ]No   |                             |                                 |   |
| Division       | To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certifice completely filled in by the funeral director,  | Certification: | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home<br>building, etc. (Specify)   | e, farm, street, facto                                | ry, office                                    |   | (Street and<br>own, State)  |                                 | ral Route Number,                                 |
|                | ne Hosp.<br>24 hou<br>16 Funer<br>letely fill   | Medical        | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exam  | ysicien: To the best of my knowle<br>niner: On the basis of examination<br>and manner stated.                  | edge, death occurre<br>n and/or investigatio          | d at the time, date a<br>n, in my opinion, de | nd place, and due to th<br>ath occurred at the time | e cause(s) a<br>e, date and | and manner as<br>place, and due | stated.<br>to the cause(s)                        |
|                | To th<br>withir<br>To th<br>comp  | Me             | 29b. Signature and title of certifier  | 3 11   | 25  | c. License number                             |   |                             | signed (Month                   |   |
|                | , i   |                | Mount  | HELL BELL  |   | RES-  | 000   | DECE                        | MBER                            | 24,2005   |
|                | 2+1   |                | 30. Name and address of person who SUSAN BELL JU   | completed cause of death (Item 2)  | 3a) (Type, Print)<br>1+05 P / TIP)                    | 601NA   | ARMINE ST   | REST. 1                     | BALTIMO                         | 24,2005<br>MARYUNNO<br>RE 21287                   |
| 45             | Sta   |                | 31. Date filed (Month) Pay, Ygar) 9  | 005 32. Segistrar's Signatur   | & Locale  | ,   | 7.110001110 011                                     |                             |                                 | -01-01  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death eadows **Physician** Dec 2005 /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner SilchRis SAltimore tospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. 209-52 10 M 2 F Hours Director Usual Residence of Decedent with the Maryland 10b. County State City, Town or Location 10d. Inside City Limits injury or other treumatic event, the Medical Examiner must be notified at HMOT Funeral Director 1 Tes 2 No 10e. Street and Number 10g. Citizen of What Country? 8 10f. Zip Code 18 à edonia , or items 23a death y 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned Blac 1 ☐ Yes 2 🗷 No Specify: ģ 3 Widowed 4 Divorced 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother permit. Peges 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 5488 Ceden: a Win 20b. Place of Disposition cometery, crematory or Town State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer COVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): signed by the attending physicien d be detached for use as the buria Records, P.O. Box 68760 Pe Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20/No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Sother (Specify) MOSPCO 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29c. License number

D \$\forall \text{30} \text{3} 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ADMIN CHARLES WY GOOD N. Charles ST BRITING MY 2/204 31. Date filed (Month, Day, Year) State Registrar

|             |   |                  | 1 - For Stata Registrar   | State of Marylan   | d / Department of H<br>Certificate of                                     |                                  | tal Hygiene                       |  | 2103  |
|-------------|---|------------------|---|--|---|----------------------------------|-----------------------------------|--|---|
|             | Physici<br>/Medio<br>Examir   | al               | 1. Decedent's Name (First, Middle, La<br>1. Decedent's Name (First, Middle, La<br>4a. Eacility Name (If not institution, giv  | ward   | Mitche<br>4b. City, Town, o   | // × M                           | ate of Death Aonth Day Cember 4c. | y Year 2/ 2005 County of Death   | 3. Time of Death                                    |
|             | Funeral<br>Director   |                  | 5. Social Security Number 6.6.  5. Social Security Number 6.6.  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60  6.60                        | PACINES HOSP,<br>ex 7. Age (18 yrs.)<br>MM 2 F 5 C   | / Fah Jack f. f. f. f. f. f. f. f. f. f. f. f. f.                         | If Under 24 Hrs. 8. Dr. (A       | ate of Sirth<br>Nonth Day, Year   | 9. Birth   | nplace (State or Foreign<br>untry)                  |
|             | death with the Maryland<br>ms 23a or 28a-1 ehow<br>Erraint by recition at   | Director         | 10a. State 10b. County  | 10c. Cit   | y, Town or Location   | )                                |                                   |  | 10d. Inside City Limits 1    Yes 2 □ No             |
|             | or death with the Maryla<br>tems 23e or 28e-f ehov<br>et mant be notified at  | Funeral Dir      | 10e. Street and Number 5521 Rade  11. Marital Status  | 12. Was Decedent Ever in U. Amed Forces?   | 10f. Zip Code 2 12 S.   13. Was Decedent of H                             | dispanic Origin? (Specify Y      | res or No-                        | 14. Race - Amer  | rican Indian,                                       |
| -0036       | hours afte<br>ural', or l   | by               | 1 Never Married Married 3 Widowed 4 Divorced  | NZYes 2 ☐ No<br>If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 No  | Specify:                         |                                   | Specify: Spe | Jack  |
| 2121        | within<br>ene.<br>then  | Completed        | (Specify only highest gra<br>Elementary/Secondary (0-12)  | College (1-4or 5+)   | (Give kind of work done life. DO NOT use refire.                          | during most of working<br>FiceR  | U                                 | letero   | WS  |
| Maryland    |   | To Be            | 17. Father's Name (First, Middle, Last, Robin Richard  19a. Informant's Name/Relationship (   | SOSON<br>Type, Print ( ) ( )   | 19b. Mailing Address (Street  | 18. Mother's Name (Firs.         | Kitck                             | 2/6  | (io Code)   |
|             | pes 1 and of Health If itam 27 or other tr  |                  | 20a Method of Disposition   |  | 2552 Radio Clare of Osposition (Name of emetery, crematory or other place | lecke A                          | re, Ba                            | Cocation - City or   | 2206  |
| Baltimore,  | permit. Pag<br>Department<br>Important:<br>eny injury o   |                  | 4 Donation 5 Other (Specifical Signature of Funeral Service Licer   | v) (50)  | MISCUTORST<br>2. Juni indapidie<br>(LOSK)                                 | sayotell<br>ssyoteacility of the | yestey                            | ings h   | Services  |
| Salar Carlo | Physician   |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition   | plications that caused the death<br>one cause on each line.  | h. Do not enter the mode of dyin  | g, such as cardiac or resp       | irratory arrest,                  |  | Approximate<br>Interval Between<br>Onset and Death  |
| 760,        | ate be executed Medical Medical Washinen and Arisinen and Porrial-transit   | Ical Examiner    | resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of the consequence o |   |                                  |                                   |  |   |
| .O. Box 68  | The law requires that the death certificat te has been signed by the attending phyage 2 should be detached for use as the | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown   | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown   | I death 3 Ectopic pregnancy   | ı                                |                                   | 23d. Date of delined Month   | very<br>Day Year                                    |
| ords, P     | w requires that<br>been signed b<br>should be deta  | ed by Pr         | Part II. Other significant conditions of  | ontributing to death but not resu  | ulting in the underlying cause giv  | en in Part I. 2                  | 23e. Did tobacco u<br>1 ☐ Yes 2 [ |  | the cause of death?                                 |
|             |   | Completed        |   |  |   |                                  | 24a. Was an autopsy performed?    | prior to c<br>death?   | topsy findings available ompletion of cause of 2 No |
| of Vita     | Physician: T<br>this certificat<br>al director, pa  | To Be            | 25. Was case referred to medical examiner? 11☐ es 2☐ No 27. Manne of Death  |  | ER/Outpatient 30 DOA Oth  | 4   Nuising nome :               | 5 Residence                       |  | ufy)  |
| Division of | Jing<br>After<br>funer  | Certification:   | 1 latural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b   | e 28e. Place of Injury - At ho   | ome, farm, street, factory, office  | Yes 2 □ No 28f. Lo               | Describe how injury               | d Number or Ru   | ral Route Number,                                   |
| Ö           | To the Hospital or Attanovithin 24 hours after death To the Funeral Director: completely filled in by the                 |                  | 29a. Certifier 1 Certifying Ph  | building, etc. (Specify  | wledge, death occurred at the tin   | ne, date and place, and du       | ity or Town, State;               | and manner as  | stated.   |
|             | To the Ho<br>within 24 to<br>To the Fu<br>completely  | Medical          | (Check only one)  2 Medical Example one)  | niner: On the basis of examinal and manner stated.   | tion and/or investigation, in my o  | pinion, death occurred at t      | the time, date and                | place, and due   | to the cause(s)                                     |
|             | /   |                  | 1 (motout   | ) Berson   | Doos  | 58946                            | 12                                | 128/05   |   |
|             | 5   | 1                | GREGORY BUBO  | complete cause of death (Item  | WEST IT   | 3Ac Tymale                       | ceru .                            | 21287  |   |
|             | Sta<br>Registi  |                  | 31. Date filed (Month, Day, Year) DEC 2 5   | 0011109711011101   | ture Apolle   |                                  |                                   |  |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year DECEMPER Elizabeth C. Miller /Medical 4b. City, Town, or Location of Death

BALTIMORE 4c. County of Death Examiner N/AIf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director 216-03-4848 96 MAY 14, 1909 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1215 Oakland Terrace Road 21227 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White ģ 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "na any injury or other traumatic aven" Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jerimiah O'Brien Sara Ann Walshe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine H. Keen/Daughter 10 Helms Pick Court Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/05 Metro Crematory, Inc. Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD, Inc. Edward A Gregorchik 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physician and d be detached for use as the burial-transit Physician/Medicai IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably 4 Unknown 1 ∏ Yes 2 ∏ No Completed YNDIDISM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other 1 Yes Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 1. Naturai 5 Pending death. investigation 1 Tyes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 🛮 🕊 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29c. License number 20 29d. Date signed (Month, Day, Year) 29b. Signature and Wantle 30. Name and address of postport of completed causerofds BALTIMORE MARMIMO 21229 31. Date filed (Month, Day, Year) State Registrar

|  |   | -                         | For<br>State<br>Registrar  |                              | State of  | f Marylan                  |  | artment<br><i>rtificate</i> |                    |                               |                             | fental Hy                       | giene<br>Reg. No.                    | )5                      | 42105  |  |
|--|---|---------------------------|--|------------------------------|---|----------------------------|--|-----------------------------|--------------------|-------------------------------|-----------------------------|---------------------------------|--------------------------------------|-------------------------|--|--|
| Р  | hysicia   | ın                        | 1. Decedent's Nam  | e (First, Midd               |   | azel Mo                    | Clinto   | nn .                        |                    |                               |                             | 2. Date of De                   | Day                                  | Year<br>OS              | 3. Time of Death                                   |  |
|  | /Medic  |                           | 4a Facility Name (   | If not institution           | on, give street and num                           |                            | Jonne  |                             | Town, or           | Location                      | of Death                    | vec.                            |                                      | inty of Deat            |  |  |
|  | xamin   | er                        |  |                              | Deaton Specialt                                   |                            |  | ,                           |                    |                               | Baltir                      | more                            |                                      | 1                       | N/A  |  |
| Fu   | ineral  |                           | 5. Social Security N   |                              | 6. Sex  | 7. Age (In yrs.            | last birthday)   | If Under<br>Months          | 1 Year<br>Days     | If Under                      | r 24 Hrs.<br>Min.           | 8. Date of Bir<br>(Month, Da    | th<br>Vegr)                          | 9. Birt                 | hplace (State or Foreign                           |  |
|  | ector   |                           | 248-56-  | -5644                        | 1 □ M 2 <b>½</b> F                                | 79                         | Yrs.   | MONTHS                      | Days               | Hours                         | (VIII).                     |                                 | 9, 1926_                             |                         | So. Carolina                                       |  |
| pu   |   |                           | Usual Residence o  | f Decedent                   |   | 100 Cit                    | y, Town or L   | nantion                     |                    |                               |                             |                                 |                                      |                         | 10d. Inside City Limits                            |  |
| aryla  | shoy  | 7                         | 10a. State   | 10b. Count                   | ,<br>N/A  | 100. 01                    | y, Town or L   | ocation                     | D.                 | altimore                      | 2                           |                                 |                                      |                         | 1 X Yes 2 □ No                                     |  |
| W e W  | or 28a-f show   | Director                  | Maryland<br>10e. Street and Nu   | mbor                         | IN/A  |                            |  | 10f. Zip                    |                    | alumore                       | <del>-</del>                | <del></del>                     | 10a Citizen                          | of What Co              | nunta/2  |  |
| with   |   |                           | 2020 Feat  |                              | ane   |                            |  | 101. Zip                    | Code               | 212                           | 207                         |                                 | 10g. Citizen of What Country? U.S.A. |                         |  |  |
| eath   | 18 23a  | era                       | 11. Marital Status   | merbed L                     |   | dent Ever in U             | .S. 13.  | Was Deced                   | ent of Hi          |                               |                             | ecify Yes or No<br>Rican, etc.) | )- 14. F                             |                         | nican Indian,                                      |  |
| :1215-0036<br>within 72 hours after death with the Maryland<br>ene.  | rltan   | Funeral                   | 1 Never Mar  | ried 2 Ma                    | Armed Fo  | 2 No                       |  |                             |                    |                               |                             | Rican, etc.)                    |                                      | Black, Whit             | e, etc.  |  |
| 030<br>ours a  | E', o   | þ                         | Widowed  | 4 Divorce                    | If Yes, Giv<br>Year or Da                         | ates:                      |  | 1 ☐ Yes 2                   | ZL <b>X</b> No     | Specify                       | <i>'</i> :                  |                                 | Specify: Black                       |                         |  |  |
| 5-0  | natu<br>dical   | Completed                 | (Spe   | 15. Decede                   | ent's Education<br>est grade completed)           |                            | (Give  | dent's Usua<br>kind of won  | k done d           | during mos                    | st of work                  | ting                            | 16b. Kind o                          | nd of Business/Industry |  |  |
| Affrin Pa  | han a   | mpl                       | Elementary/Sec   |                              |   | -4or 5+)                   | life.  | DO NOT us                   |                    |                               | or.                         |                                 | Maryl                                | and Hist                | torical Society                                    |  |
| S II S V V S II S V S II S V V S  | thar t  |                           | 17. Father's Name  | (First Middle                | (ast)   | -                          | 1  |                             | nous               | 18. Moth                      |                             | e (First. Middle                | . Maiden Sun                         | laiden Sumame)          |  |  |
| Maryland 21215-0036 td 2 should be illed within 72 hours aff lith and Mental Hygiene.  | : If item 27 is marked other than 'natural', or Itams 23a<br>or other traumatic avent. It a Medical Examinational | To Be                     | 17. 1 &(1101 3 1441110   |                              | sevelt Sanders                                    |                            |  |                             |                    | 10.111007                     |                             |                                 | Mae Sar                              |                         |  |  |
| shoul M  | mat   | -                         | 19a. Informant's N   | lame/Relation                | nship (Type, Print)                               |                            | 19b. Maili   | ing Address                 | (Street a          | and Numb                      | er or Rui                   | al Route Numb                   | er, City or To                       | wn, State, 2            | Zip Code)  |  |
| Mand 2   | 27 is<br>er tra   |                           | Dorothy M  | 29                           |   |                            |  |                             |                    |                               |                             |                                 |                                      |                         |  |  |
| Baltimore, Ma<br>permit. Pages 1 and 2<br>Department of Health a   | r oth   |                           | 20a. Method of Dis   |                              | 3 Removal from                                    |                            | Place of Disponentery, cre                             | osition (Namematory or ot   | ne of<br>ther plac | :e)                           |                             | Date                            | 20c. Location                        | on - City or            | Town, State  |  |
| imc<br>Page  | ant: H  |                           | `4 ☐ Donation  |                              |   | State                      | Loud   | lon Park                    | Ceme               | etery                         |                             | 12/29/05                        |                                      | Baltimo                 | re, Md.  |  |
| att  | Import<br>any inj<br>once.  |                           | 21. Signature of F   | uneral Servic                | e Licersee  | +                          | $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ $\bigcirc$ | 2. Name and                 |                    |                               | •                           |                                 | D 4                                  |                         |  |  |
| <b>m</b> %ă  | 트등의   |                           | lec  | W                            | Cu.C  | SLED                       | DK   | Ls<br>13                    | tep B              | rothers<br><del>Itaw Pl</del> | s Fune<br><del>ace Ba</del> | ral Service,<br>altimore, M     | d 21217                              |                         |  |  |
| 100.00   |   |                           | 23a. Part1. Enter<br>shock, or her   | the disease, art failure. Li | or complications that c<br>st only one cause on e | aused the deat<br>ach line | h. Do not en   | iter the mode               | e of dyin          | g, such as                    | s cardiac                   | or respiratory a                | rrest,                               |                         | Approximate<br>Interval Between<br>Onset and Death |  |
|  | sician :  |                           | Immediate Cause<br>disease or conditi  | on                           | a   | Pull                       | YONAR  | y GH                        | BOL                | 15M                           |                             |                                 |                                      | IMA                     | LEDIKTE  |  |
|  | /Medical<br>Examiner  |                           | resulting in death)  | ,                            | Due to (  | or as a consec             | CLON   | in VA                       | SCULITIZ           |                               |                             | FLUS                            |                                      |                         |  |  |
| 1  |   | 40                        | Sequentially list of   | onditions,                   | b   | or as a consec             | uence of): i   | CLEKU                       | -110               | Chien                         | N V/C                       | >CCC LITTE                      |                                      |                         | 3 1 9 60363  |  |
| - DE   | unsit   | Examiner                  | Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |                              |   |                            |  |                             |                    |                               |                             |                                 |                                      |                         |  |  |
| 2, 'S  | hysician and<br>the burial-transit  | Еха                       | resulting in death) Last  Due to (or as a consequence of):   |                              |   |                            |  |                             |                    |                               |                             |                                 |                                      |                         |  |  |
| 8760<br>8760   | ysicia<br>e bur   | dicai                     |  |                              | d   |                            |  |                             |                    |                               |                             |                                 |                                      |                         |  |  |
|  |   | Medi                      | IE EENAN E.  |                              | =20   |                            |  |                             |                    |                               |                             |                                 |                                      |                         |  |  |
|  | r use   | an/h                      | IF FEMALE:<br>23b. Was deceded   |                              | 23c. If yes, out 1 ☐ Live b                       | come of pregna             |  | □Ectopic pre                | egnancy            | ,                             |                             |                                 | 23d.                                 | Date of del             | livery<br>Day Year                                 |  |
| C. B.  | he atl  | sicia                     | in the past 12   | No                           | 4□Pregn<br>9□Unkno                                | ant at time of o           | death 5  | Other (spe                  | ecify)             |                               |                             |                                 |                                      | MOTH                    | Day 1 bai  |  |
| P.O.   | d by t<br>etach   | Phy                       | 9 Unknow   |                              | tions contributing to de                          | anth hut not roo           | ulting in the  | undoshring or               | 21120 221          | on in Bod                     |                             | 23e Did                         | tobacco use o                        | contribute to           | the cause of death?                                |  |
| NECL MCCL<br>Records, P.O. Box 6<br>The law requires that the death certific   | as been signed by the attending t<br>2 should be detached for use as  | Completed by Physician/Me | DIAGE TES  | KELLIT                       |   | >HERIAL                    |  | L H-Z                       |                    |                               |                             |                                 | Yes 2□N                              |                         | robably 4 Unknown                                  |  |
| 7 Octo   | peen  | etec                      | 0. 7. 5.   | * 1                          | 1   |                            |  |                             |                    |                               |                             | 1 = 24a. Was                    | 20 20                                | th More a               | stongy findings available                          |  |
| Rec 3ec  | has l   | mpl                       | HMPUTA   | 1100                         | TRAECHOS  | 1                          |  |                             | 152                | 1 Ku                          |                             | auto                            | psy<br>ormed?                        | prior to<br>death?      | utopsy findings available completion of cause of   |  |
| autop performance of the second of the secon |   |                           |  |                              |   |                            |  |                             |                    | 2.25 No                       | 1 🗆 Yes                     | 2 🗀 No                          |                                      |                         |  |  |
| Vit  | recto   | o Be                      | 25. Was case reference examiner?   | No Medic                     | Hogarital:  | npatient 2                 | ER/Outpatie  | ent 3 DO                    | Oth                | O.C.                          |                             | th (Check only)                 |                                      | Other (Spe              | cotto)   |  |
| of<br>Phy  | or this<br>eral d   | To To                     | 27. Manner of Dea  |                              | 28a. Date   | of Injury                  | 28b. Time  |                             | 8c. Injun<br>Worl  |                               | idising in                  | 28d. Describe                   |                                      |                         | City)  |  |
| on ding  | r: Afte   | atlo                      | 1 Natural 2 Accident   | 5 Pend<br>inves              | ding (Mon.  | th, Day Year)              | Injury   | М                           |                    | k?<br>Yes 2□                  | ]No                         |                                 |                                      |                         |  |  |
| 片さぎた<br>Division of Vital Records<br>or Attanding Physician: The law requires<br>after death.  | ector<br>by th  | iffica                    | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 ☐ Coul<br>dete             | mined 200. Flace                                  | of Injury - At h           |  | treet, factory              | , office           |                               |                             |                                 | Street and No                        | umber or Ro             | ural Route Number,                                 |  |
| talog Circumstantia  | al Dir  | Certification:            |  |                              |   |                            |  |                             |                    |                               |                             |                                 |                                      |                         |  |  |
| Division of Vital To the Hospitel or Attending Physicien:  | To tha Funeral Director: After this certificate hi completely filled in by the funeral director, page             | Medical                   | 29a. Certifier<br>(Check only  |                              | ying Physician: To the al Examiner: On the b      | asis of examina            |  |                             |                    |                               |                             |                                 |                                      |                         |  |  |
| tha h  | tha f   | Med                       | one)<br>29b. Signature an  | d title of certif            |   | ner stated.                |  | 290                         | License            | e number                      |                             |                                 | 29d. Date si                         | aned (Mont              | h, Day, Year)                                      |  |
| O TANK   | <u>-</u> 00   | _                         | Lau. Signature an  | 0.40                         | Flym w  | )                          |  | 1                           | A 1                | 346                           |                             |                                 | Das                                  | اردون                   | 2  |  |
|  | 1   |                           | 20 115   | drang of                     | on who completed caus                             | e of death (Ite            | m 23a) /Tues   | Print)                      | -                  |                               |                             |                                 | yee,                                 | LTR                     | ALTINO?  |  |
|  | Į.  |                           | J. Flant   | I A                          | NIVERSITY   | SPEN                       | HCTU   | HUSVI                       | MAI                | _ 611                         | 5, C                        | IHARL                           | E 5 2                                | 212:                    | 3D   |  |
| t T  | Sta   | tė                        | 31. Date filed (Mo   | onth, Day, Yea               | / /   | legistrar's Sign           |  | . ///                       |                    | E 1 [                         |                             |                                 |                                      |                         | -  |  |
|  | Registr   |                           | 31. Date filed (Mo   | C Z 9 2                      | 005   | L de                       | Spinster.  |                             |                    |                               |                             |                                 |                                      |                         |  |  |

|                          |   |                     | Please Type or Print in I  State of Marylar  1- State Registrar  | nd / Depa  | delible Ink. Ensure A<br>artment of Health and N<br>dificate of Death | Mental Hygi                                 | 99005   | 42106  |  |
|--------------------------|---|---------------------|--|--|---|---|---|--|--|
| -                        | 2005  |                     | Registrar  1. Decedent's Name (First, Middle, Last)  |  |   | 2. Date of Death                            |   | 3. Time of Death   |  |
| 1. 15%                   | Physici   |                     | Leland Kendall Murray, Sr.   |  |   | Decembe                                     | r <sup>Day</sup> 5, 2005  | 7:55 p м   |  |
| Jr.                      | /Media  |                     | 4a. Facility Name (If not institution, give street and number)   |  | 4c. County of Deat  |   |   |  |  |
| M - 1                    |   |                     | Stella Maris Hospice   |  | Timonium  |   | Baltimor  |  |  |
| 100                      | Funeral   |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. 1 € M 2 F   | last birthday)<br>Yrs.   | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.              | 8. Date of Birth<br>(Month, Day,<br>Sept. 5 | Year) 9. Birti  | nplace (State or Foreign<br>unity)<br>y Land               |  |
| W <sub>q</sub>           | Director  |                     | 220-18-3882 80 Usual Residence of Decedent   | 113.   |   | Sept. 5                                     | , 1923 Hal  | yrand  |  |
|                          | anyland<br>ehow   |                     |  | ty, Town or Lo   | cation<br>arkville  |   |   | 10d. Inside City Limits                                    |  |
|                          | a-fet   | ctor                | Md. Baltimore  |  |   | 1 ☐ Yes 2 ☐ No                              |   |  |  |
| 36                       | uth with the<br>23a or 28<br>ust be no  | Funeral Director    | 10e. Street and Number 8609 Midi Avenue  10f. Zip Code 21234  10g. Citizen of What Country? U.S.A.   |  |   |   |   |  |  |
|                          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once. | ρ                   | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Norced  1 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 □ No Specify:  |  |   | Bfack, White                                | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White   |  |  |
| 9                        | 2 hou   | ted                 | 15. Decedent's Education (Specify only highest grade completed)  | 16a. Deced   | dent's Usual Occupation<br>kind of work done during most of work      | 100   | 16b. Kind of Business/  | Industry   |  |
| 21215-0036               | ithin 7   | Completed           | Elementary/Secondary (0-12) College (1-4or 5+)   | life. L  | DO NOT use retired)   | ung   |   |  |  |
| CA                       | led wi<br>ygien<br>her th   | S                   | 12 years   | sales  | person  | - (Fina Mindu A                             | carpet co   | mpany  |  |
| Maryland                 | ould be fil<br>Mental H<br>arked ott  | To Be               | 17. Father's Name (First, Middle, Last) Kendall L. Murray  |  |   | ne (First, Middle, M<br>lae Doerr           |   |  |  |
| Mar                      | 12 sh<br>h and<br>7 ie m<br>rraum   |                     | 19a. Informant's Name/Relationship (Type, Print)  Leland Kendall Murray, Jr./so:   |  | ng Address <i>(Street and Number or Ru</i><br>. Ady Road, Forest      |   |   | (ip Code)  |  |
|                          | 1 and<br>Health<br>em 2   |                     | 20a Method of Disposition 20b.   | Place of Dispos  | sition (Name of   | -   | 20c. Location - City or   | Town, State  |  |
| nor                      | ages<br>int of<br>t: if it  |                     | 1 Burial 2 □ Cremation 3 □ Removal from State  |  | s Ch. Cem. 12/29  |   | ylesville,  |  |  |
| Baltimore,               | permit. P<br>Departme<br>Importan<br>any injury   |                     | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Ucensee  22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc.   |  |   |   |   |  |  |
|                          | 40260   |                     | 232 Part 1 Enter the disease or complications that caused the dea  | 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate |   |   |   |  |  |
| Records, P.O. Box 68760, | bath certificate be executed attending physicien and for use as the burial-transit  | icai Examiner       | disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consect of the conditions of the cause of the conditions of the conditions of the cause of the conditions | quence of):  | ARDIOVASCULAR DIS   | EASE  |   |  |  |
|                          | requires that the death certificate be executed seen signed by the attending physicien and hould be detached for use as the burial-transit  | by Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant at time of one of the past 12 months? 4 ☐ Pregnant at time of one of the past 12 months? 9 ☐ Unknown   | al death 3 □   | □Ectopic pregnancy<br>□ Other (specify)                               |   | 23d. Date of del<br>Month   | ivery<br>Day Year  |  |
|                          | quires that the de<br>n signed by the a<br>uld be detached f  |                     | Part II. Other significant conditions contributing to death but not re-  | sulting in the ur  | nderlying cause given in Part I.                                      |   | eacco use contribute to<br>s 2 □ No 3 □ Pr                            | the cause of death?  |  |
|                          | ysician: The law requires oertificate has been si director, page 2 should I   | Completed           |  |  |   | 24a. Was ar<br>autops<br>perform<br>1 Yes 2 | y prior to oned? death?   | topsy findings available<br>completion of cause of<br>2 No |  |
| Vital                    | Physician:<br>this certificantal director,  | Be                  | 25. Was case referred to medical examiner?   |  |   | th Check only one                           | 9)  |  |  |
| of V                     | hysic<br>this co  | ၉                   | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2   |  |   |   | nce 6 X Other (Spe  | HOSPICE  |  |
| Division o               | snding P<br>seth.<br>or: After t<br>he funera   | Certification:      | 2 Accident investigation   | 28a. Date of Injury (Month, Day Year)  28b. Time of lnjury  Nork?  1 ☐ Yes 2 ☐ No  |   | 28d. Describe how injury occurred           |   |  |  |
| DIVI                     | tal or Att<br>rs after d<br>al Direct<br>ed in by   | Certifi             | 3 Suicide 6 Could not be determined 28e. Place of Injury - At houricide 28e. Place of Injury - At houriding, etc. (Special Coulding)   | iome, farm, str  | eet, factory, office  |   | cation (Street and Number or Rural Route Number,<br>y or Town, State) |  |  |
|                          | To the Hospital or Attending Phys within 24 hours after deeth. To the Funeral Director: After this: completely filled in by the funeral director.   | edicai              |  |  |   |   |   |  |  |
|                          | Tot<br>with<br>Tot  | Σ                   | 29b. Signature and title of certifier  |  | 29c. License number  D 43725  | 29  | Pd. Date signed (Month) $12/27/$                                      |  |  |
| 100                      | 119   |                     | 30. Name and address of person who completed cause of death (Ite   | m 23a) (Type,  |   |   | ,   | -  |  |
| W                        |   |                     | DR. TARIQ MAHMOOD 2300 DULANE  |  | EY RD. TIMONIUM,  | MD 2109                                     | 3   |  |  |
| 100 mg                   |   | ate                 | 31. Date filed (Month, Day Xear) 9 2005 32. Refisirar's Sign   | ature #  | Snack &   |   |   |  |  |
| DL                       | Regist  |                     | January January  | 10 19  |   |   |   |  |  |

DHMH 17 Rev 1/2001

|  |  |                        | State of Maryland / Department of Health and M  1 - State Registrar Certificate of Death  | 1   | 1000 47107   |  |  |  |  |
|--|--|------------------------|---|---|--|--|--|--|--|
| 24   |  | 3                      | Registrar  Certificate of Deatiff  Decedent's Name (First, Middle, Last)  | Reg. I  | 3. Time of Death   |  |  |  |  |
|  | Physici<br>/Medic  |                        | Dennis H. Manny   | Do C  | 25 2005 7:37PM   |  |  |  |  |
| Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  University of Maryland Medical Center Baltim |  |                        |   |   | 4c. County of Death  |  |  |  |  |
| 10,  | Funeral  | h.                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  | 8. Date of Birth<br>(Month, Day, Yea  | 9. Birthplace (State or Foreign                                      |  |  |  |  |
| -142.  | Director   |                        | 162 <b>-</b> 36-9835  | 6-30-194  | 5 PA.  |  |  |  |  |
|  | and  |                        | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |   | 10d. Inside City Limits  |  |  |  |  |
|  | Mary<br>- sho  | Director               | MD Baltimore Halethorpe 1□Yes 2√xN  |   |  |  |  |  |  |
|  | h the<br>or 288  |                        | 10e. Street and Number 10f. Zip Code  | 10g. (  | Citizen of What Country?   |  |  |  |  |
|  | 23a c  | aiD                    | 18 Birdknoll Court 21227  |   | U.S.A.   |  |  |  |  |
|  | tems   | Completed by Funeral   | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto f   | ecify Yes or No-<br>Rican, etc.)  | <ol> <li>Race - American Indian,<br/>Black, White, etc.</li> </ol>   |  |  |  |  |
| 36   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>other than "natural", or Itema 23s or 28s-f show<br>ent, the Medical Evaninal must be notified at   |                        | 1  Never Married 2  Married   |   | Specify: White   |  |  |  |  |
| Š  | 2 hou  |                        | 15. Decedent's Education 16a. Decedent's Usuaf Occupation   | 16b.  | 6b. Kind of Business/Industry  |  |  |  |  |
| 215  | thin 7   |                        | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of working life. DO NOT use retired)   |   |  |  |  |  |  |
| 2  | led wi<br>lygien<br>her th   |                        | 2 IT Tech   |   | S Government   |  |  |  |  |
| Maryland 21215-0036  | ntal H<br>od otl   | Be                     |   | (First, Middle, Maid  |  |  |  |  |  |
| Ë  | should<br>nd Me<br>mark<br>matic   | 은                      | Charles Henry Manny Ruth Ar  19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura   | letta Hip   | <u> </u>   |  |  |  |  |
|  | nd 2 salth ar<br>27 is<br>r trau   |                        | Mrs. Ethel Hund / Sister 270 Glenda Court; Mille  |   |  |  |  |  |  |
| ē,   | s 1 a<br>of Hea<br>item  |                        | 20a. Method of Disposition 20b. Place of Disposition (Name of D   |   | Location - City or Town, State                                       |  |  |  |  |
| altimore,  | Page<br>ment<br>ant: if<br>ury or  |                        | 1 🗆 Buria: 2 🗀 Cremation 32 🖺 Hemoval from State  | 9-2005 Ne   | w Cumberland, PA   |  |  |  |  |
| Balt   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once. |                        | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Sin 1 Second Ave SW; G1   |   |  |  |  |  |  |
|  |  |                        | 23a. Part1. Ester the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  | or respiratory arrest,  | Approximate<br>Interval Between                                      |  |  |  |  |
| - 3  | Physician  |                        | Immediate Cause (Final disease or condition April Ston 05)5   |   | Onset and Death  |  |  |  |  |
|  | /Medical<br>Examiner   |                        | resulting in death)  Due to (or as a consequence of):   |   |  |  |  |  |  |
| 2  |  | -e                     | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):   |   |  |  |  |  |  |
| V  | uted<br>3<br>ansit   | Examiner               | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   |   |  |  |  |  |  |
| Ó  | exec<br>en an  | Exa                    | resulting in death) Last Due to (or as a consequence of):   |   |  |  |  |  |  |
| 8760   | cate be executed physicien and the burial-transit  | dicai                  | d   |   |  |  |  |  |  |
| 9  | ertific<br>ding p  | /Mec                   | IF FEMALE: 230 If year outcome of progressiv  |   |  |  |  |  |  |
| Вох  | The law requires thet the death certificate has been signed by the attending prage 2 should be detached for use as   | Physician/Me           | 23b. Was decedent pregnant in the past 12 months?  1  |   | 23d. Date of delivery  Month Day Year                                |  |  |  |  |
| o.   | thet the de<br>ed by the s<br>detached t   | hysi                   | 1 Yes 2 No 9 Unknown 9 Unknown  |   |  |  |  |  |  |
| ď.   | res thei<br>igned t<br>be det  | by P                   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobacci  | o use contribute to the cause of death?                              |  |  |  |  |
| ğ  | w require<br>been sig<br>should b  |                        |   | 1 🗆 Yes   | 2 No 3 Probably 4 □Unknown   |  |  |  |  |
| Records,   | e law r<br>has be<br>ge 2 sh   | Be Completed           |   | 24a. Was an autopsy   | 24b. Were autopsy findings available prior to completion of cause of |  |  |  |  |
| E  |  |                        |   | performed?<br>1  Yes 2 ∠V   | death?   |  |  |  |  |
| Vita   | Physician: Th<br>this certificate<br>ral director, pag   |                        | 25. Was case referred to medical examiner?  Hospital: 17 yes 20 No Other: 4 Thursday Hospital: 18 Page 19 19 19 19 19 19 19 19 19 19 19 19 19   |   |  |  |  |  |  |
| ō  | Phys<br>or this<br>oral di   | To                     | 1 supation 2 Ervoutpation 3 DOA 4 Nutsing Hon   | me 5 Residence<br>28d. Describe how in  | 6 ☐ Other (Specify) jury occurred                                    |  |  |  |  |
| Division of  | Attending<br>ir death.<br>ector: After<br>by the funer   | Medical Certification: | 1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No  |   |  |  |  |  |  |
|  | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral   |                        | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |  |
|  | Hospital<br>24 hours<br>Funeral<br>stely filled  |                        | 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  |  |  |  |
|  | To the Hospital or within 24 hours after To the Funeral Dir completely filled in   |                        | (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.   |   |  |  |  |  |  |
|  | To<br>To   |                        | 29b. Signature and utile of certifier  29c. License number  AU4176435 W  30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  ANGELA Wortham MD University of Mark  31. Date-filed (Month, Day, Year)  DEC 2 9 2005  32. Registrar's Signature  DEC 2 9 2005 | 290.  | oale signed (Montin, Day, Year)                                      |  |  |  |  |
| ,  | $\cap$   |                        | 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)  | 116/11/10   | 20, 2005   |  |  |  |  |
| _  | 7  |                        | Angela Wortham MD, University of Mars   | yland n   | Medical Center   |  |  |  |  |
|  | Sta  |                        | 31. Date-filed (Month, Day, Year)  32. Registrar's Signature  |   |  |  |  |  |  |
| -  | Registr  | ar                     | DEC 2 9 2005  |   |  |  |  |  |  |

|  |            |  |  | State of Maryland / Department of Certificate of Registrar   | f Health and M                                       | •  | -  | 62108  |  |
|--|------------|--|--|--|--|--|--|--|--|
|  |            |  |  | Registrar  1. Decedent's Name (First, Middle, Last)  | Dealli   |  | g. No.                                   |  |  |
|  | 4          | Physic<br>/Medi  |  | Robert Ray Montgomery  |  | 2. Date of Death<br>Month<br>December        | Day Year                                 | 3. Time of Death<br>10:43 PM                     |  |
|  | 4          | Exami  | ner  |  | n, or Location of Death                              |  | 4c. County of Deal                       | th   |  |
|  |            |  |  |  | e de Grace   |  | Harfor                                   |  |  |
|  |            | Funeral<br>Director  |  | 5. Social Security Number 219-12-0079 6. Sex 1 M 2 F 82 Yrs. 1 M onths Day   | ys Hours Min.  | 8. Date of Birth<br>(Month, Day,<br>April 19 | 9. Birt<br>Co<br>Vi                      | hplace (State or Foreign<br>buntry)<br>rginia    |  |
|  |            | and w  |  | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location   |  |  |  | 10d Jacida Cita Limita                           |  |
| 3  |            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other treumatic event, I'm Medical Examinat must be notified at once.  | ctor   | Vîrginia Lee Rose Hill   |  |  |  | 10d. Inside City Limits 1 ☐ Yes 2 💢 No           |  |
| 20   |            |  | Funeral Director   | 10e. Street and Number  Route 1, Box 368  10f. Zip Code 24281  |  |  | g. Citizen of What Co<br>Jnited Sta      |  |  |
|  |            | ems  | ner  | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, specify C   | of Hispanic Origin? (Spe<br>Juban, Mexican, Puerto I |  | 14. Race - Ame                           | rican Indian,                                    |  |
| ~  | 9          | or the   | Fu   | 1 X Never Married 2 Married 1 X Yes 2 No   |  | Hican, etc.)                                 | Black, White                             |  |  |
| (1.  | 5-0036     | urel',   | d by   | Year or Dates: WW 11   |  |  | Specify: W                               | nite   |  |
| 7  |            | within 72 h<br>ene.<br>then "nett  | Completed  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occ (Give kind of work dor life. DO NOT use reti   | cupation<br>ne during most of workii<br>ired)        | ng 16  | 6b. Kind of Business/                    | Industry   |  |
| 5  | 212        | filed w<br>Hygier<br>Ither th  | Cor  | 7 factory work   | er   | C  | coal proce                               | ssing  |  |
| کے   | ng         | be fill  | To Be  | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name                                    |  | ,  |  |  |
| Ö  | Tactory wo |  |  |  | Cornie El  |  |  |  |  |
| 3  | Maryland   | s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other then other treumatic event, the Mental Control of the Mental Contro |  | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Streen Billy R. Montgomery/brother  3413 Old Court   |  | Route Number, C<br>.kesville                 |  |  |  |
| -  | Fe,        | es 1 and 2<br>of Health<br>fitem 27 i  |  | 20a. Method of Disposition 20b. Place of Disposition (Name of  | . D  |  | Oc. Location - City or                   |  |  |
| 0  | Ë          | Page<br>sent c<br>nt: #<br>ry or   |  | 1 □ Burial 2 ▼ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)   | 1  | 2005   | Doltimone                                | Mousel and                                       |  |
| 5  | Baltimore, | permit. Pag<br>Department<br>Importent: I<br>any injury c  |  | OLCCIMOUIT CLEME   | dress of Facility<br>hell-Wiedef<br>York Rd          | eld Fune                                     | ral Home.                                | , Maryland<br>Inc.                               |  |
|  |            | 40260  | _  | 0,000  | TOTA TOTA  | Dallelin                                     | ILC. IIII Z                              | 1212   |  |
| ."43   |            | Pnysician<br>/Medical<br>Examiner  | ler  | 23a. Bef1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  Due to (,'r as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  |  |  |  |  |  |
|  | 68760, 🖉   | eath certificate be executed<br>attending physician and<br>for use as the burial-transit   | edical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   |  |  |  |  |  |
| 36/05  | .O. Box    | LIVISION OT VITAI RECORDS, P.O. BOX 68  To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Medi   |  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)  | ісу  |  | 23d. Date of deliv<br>Month              | very<br>Day Year                                 |  |
| 0  | ds, F      | ires tha<br>signed<br>d be de  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  | co use contribute to the cause of death? |  |  |
| -  | Recor      | w requ   | Completed  | Alain Hilalla Lin  |  | 1 Tes  |  | bably 4 Unknown                                  |  |
|  | Re         | he la<br>e has<br>ige 2  | dmo  | Agrice Figuriania  |  | 24a. Was an autopsy performed                | / prior to co                            | opsy findings available<br>ompletion of cause of |  |
|  | <u>ro</u>  | ificate<br>or, pa  | e Cc   | 25. Was case referred to medical   |  | 1□ Yes 2☑                                    |  | 2 🗌 No   |  |
|  | of Vital   | s cert<br>irect  | o Be   | examiner?  | 26. Place of Death                                   |  |  | -  |  |
|  | o          | y Phy<br>ar this<br>aral c   | $\vdash$   | The state of the s |  |  |  |  |  |
|  | ion        | ath.<br>r: Afte  | atio   |  | lork?<br>□Yes 2□No                                   |  | ,.,,                                     |  |  |
|  | Division   | iel or Attendii<br>s after death.<br>el Director: A<br>ed in by the fu   | Certification:   | 3 Suicide 4 Homicide  Global Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street at City or Town, State)  |  |  |  | and Number or Rural Route Number,<br>te)         |  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one) |            |  |  |  |  | e(s) and manner as s<br>and place, and due t | stated.<br>o the cause(s)                |  |  |
|  |            | To th<br>Withir<br>To th<br>Sompl  | Me   |  | nse number   | 29d.   | Date signed (Month,                      | Day, Year)                                       |  |
|  |            | \  |  | Van Deras I3   | 39944  | 0  | 0001-0-                                  | 777ME  |  |
|  | 0          | ) ^ [  |  | 30. Name and a ses of person who completed cause of death (Item 23a) (Type, Print)   |  | 2  | - ENGOLI                                 | ci, cus  |  |
|  |            | 1 5  |  | Apurva Desai , M.D. 501 S. Union Ave. Havre  | de Grace,  | Maryland                                     |  |  |  |
|  |            | Sta<br>Registra  |  | 31. Date filed (Month, Day, Year)  DEC 2 9 2005  Registrar's Signature   |  |  |  | 77   |  |

DHMH 17 Rev 1/2001

|              |   |                  | For<br>State<br>Registrar   | State of Ma  | aryland                  |                          | artment<br>rtificate                                       |                                     |  |  | iene 05                             | 421   | 09                      |
|--------------|---|------------------|---|--|--------------------------|--------------------------|--|-------------------------------------|--|--|-------------------------------------|---|-------------------------|
|              | Physici<br>/Medi  |                  | Decedent's Name (First, Middle, Li THOMAS ANDRE   | ,  |                          |                          |  |                                     |  | 2. Date of Deat<br>Month<br>Decembe          | Day                                 | 3. Time (                                       | of Death<br>354M        |
|              | Examir  |                  | 4a. Facility Name (If not institution, gi<br>ROLAND PARK PL   |  | ENTER                    |                          |  | wn, or Loca<br>Lmore                | city                                   |  | 4c. County o                        | f Death   |                         |
|              | Funeral<br>Director   |                  | 577-34-3982   | Sex 7. Ag<br>1 ☑ M 2 ☐ F   | e (In yrs. lasi<br>78    | t birthday)<br>Yrs.      | If Under 1<br>Months [                                     |                                     | Inder 24 Hrs.<br>ours Min.             | 8. Date of Birth (Month, Day, Nov 10,        |                                     | 9. Birthplace (State<br>Country)<br>Kansas      | or Foreign              |
|              | 72 hours after death with the Maryland natural; or items 23e or 28a-1 ahow olds! Experient must be notified at  | rector           | Usual Residence of Decedent  10a. State 10b. County  Maryland  10e. Street and Number   | N/A  | 10c. City, T             |                          | nore C   | -                                   |  | 11   | ng. Citizen of Wi                   | Λ   | City Limits<br>s 2 ☐ No |
| .0           | be filed within 72 hours after death with the Marylan<br>Ital Hygiene<br>of other than "natural", or items 23e or 28a-f ahow<br>event. I're Madical Exprirer must be notified at  | Funeral Director | 3811 Canterbury  11. Marital Status  1 Never Married 2 Married  | Road, Apt  12. Was Decedent Armed Forces? 1 12 Yes 2                     | Ever in U.S.             |                          | f Yes, specify   | Cuban, Me                           | ic Origin? (Spaxican, Puerto           | ecify Yes or No-<br>Rican, etc.)             | 14. Race                            | USA<br>- American Indian,<br>, White, etc.      |                         |
| 21215-0036   | n 72 hours a<br>"natural", o  | by               | 3 Widowed 4 ☐ Divorced  15. Decedent's E (Specify only highest gi   | Year or Dates:   |                          | 16a. Dece                | 1 ☐ Yes 25<br>dent's Usual (<br>kind of work<br>DO NOT use | Decupation                          | ecify:<br>n most of work               | ing  | Specify:                            | White iness/Industry                            |                         |
| nd 212       | e filed within all Hygiene lother than "lother than "vent, If e Mex   | Be Completed     | Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las  | College (1-4or 5 +   | 5+)                      |                          | essor  |                                     | Mother's Name                          | e (First, Middle, M                          |                                     | ge Educat                                       | ion                     |
| Maryland     | iges 1 and 2 should be it of Health and Mental it if item 27 Is marked o or other traumatic eve   | Tof              | Cecil  19a. Informant's Name/Relationship  Months V. Clause   |  |                          |                          |  |                                     |  | al Route Number,                             |                                     | itate, Zip Code)                                |                         |
| Baltimore, I | permit. Pages 1 and<br>Department of Healti<br>Importent: If item 2:<br>any injury or other it  |                  | Martha V. Glenn  20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Socc  21. Sign Met of Fundral Sew. Aid  Martin D. Au              | Removal from State   | 20b. Plac<br>cem<br>Gree | etery, crer              | sition (Name<br>natory or othe<br>int Cre                  | er place)<br>emator<br>Address of l | Facility                               | 8/2005 I                                     | altinor                             | Maryland ity or Town, State  Maryla  Inc.       | and                     |
| HUSSIN       | Physician<br>/Medical<br>Examiner   |                  | Martin D. Lau 23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)    | nplications that caused one cause on each line.  a. End S  Due to (or as | terqu                    | Pa                       |  |                                     | ad, Ba<br>ch as cardiac<br>i<br>S Clus |  | Maryla:                             | nd 21212<br>proving<br>Interval Be<br>Onset and | ate<br>atween           |
| 8760,        | cale be executed physician and the burial-transit   | fical Examiner   | Sequentially list conditions, it any reaching to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Oue to (or as Due to (or as d.  |                          | ·                        |  |                                     |  |  |                                     |   |                         |
| P.O. Box 6   | law requires that the death certifics<br>as been signed by the attending pt<br>2 should be detached for use as t  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown | 2 Fetal de               | ath 3                    | Ectopic preg<br>Other (spec                                |                                     |  |  | 23d. Date<br>Mont                   | ,   | Year                    |
|              | w requires that<br>been signed b<br>should be deta  | by               | Part II. Other significant conditions Recumatic R   |  |                          | -                        | nderlying cau  | -                                   |  |  |                                     | oute to the cause of                            |                         |
| l Records,   | The<br>ate h  | Completed        | Autral and  | arrho  | wat                      | lue                      | repl   | acen                                | enta                                   | 24a. Was ar<br>autopsy<br>perform<br>1 Yes 2 | pri<br>de                           | ere autopsy findings or to completion of ath?   | s available<br>cause of |
| Vital        | sicien:<br>certific<br>rector,  | Be               | 25. Was case referred to medical examiner?  1  Yes 2  No  | Hospital:  |                          |                          |  | Othor                               |  | (Check only one                              |                                     |   |                         |
| of           | ding<br>Afte<br>fune  | atlon; To        | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  |  |                          | Bb. Time of<br>Injury    | t 3 DOA<br>28c   | Injury at Work?                     |  | me 5 Reside<br>28d. Describe ho              |                                     |   |                         |
| Division     | Direction of  | Certification;   | 3 Suicide 6 Could not determined  | building, et   | c. (Specify)             |                          |  |                                     |  | City or Town                                 | State)                              | or Rural Route Nur                              | πber,                   |
|              | To the Hospital within 24 hours a To the Funeral I completely filled  | Medical          | 29a. Certifier  (Check only one)  1 Certifying P 2 Medical Exa  | hysicien: To the best<br>miner: On the basis o<br>and manner st          | f examination            | adge, death<br>and/or in | occurred at<br>vestigation, in                             | the time, da<br>my opinion          | te and place,<br>, death occurr        | and due to the ca<br>ed at the time, da      | use(s) and mani<br>te and place, an | ner as stated.<br>Id due to the cause(          | s)                      |
| )            | To the To the Complex | Σ                | 29b. Signature and title of certifier  M. Babelle   | Macgre   | eger                     | h D                      |  | icense num                          |  |  |                                     | (Month, Day, Year)<br>Ur 27, 2                  | 005                     |
|              | þ   |                  |   | THE GREGO  |                          |                          | Print)<br>40 %   | STRE                                | ET) B                                  | A2570781                                     | RE, MD                              | 21211   |                         |
| 1            | Stá<br>Registi  |                  | 31. Date filed (Month, Day, Year)   | and the second   | ar's Signatur            |                          | ack s  |                                     |  |  |                                     |   |                         |

|            |  |                     | 1- For State of Maryland /   |                   | artmen                   |                      |                           | and M                 | F                               | Reg. No          | UU           | 5 4               | 211   | 0          |
|------------|--|---------------------|--|-------------------|--------------------------|----------------------|---------------------------|-----------------------|---------------------------------|------------------|--------------|-------------------|---|------------|
| Н          | Physici  | an                  | 1. Decedent's Name (First, Middle, Last)  Dorothy Brittingham Cecil McSorle  |                   |                          |                      |                           |                       | 2. Date of Dea<br>Month         | Da               | iy o         | Year              | 3. Time of                                  |            |
|            | /Medi<br>Examir  |                     | 4a. Facility Name (If not institution, give street and number)   | у                 | 4h City                  | Town or              | Location of               | of Death              | Decembe                         |                  | . County     | 005               | 3:55  | Рм         |
| 1          | Examir   | ler                 | 5100 N. Charles St.  |                   |                          | timo                 |                           | Deau                  |                                 | 40               | N/           |                   |   |            |
|            | Funeral  |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last b  | oirthday)         | If Under<br>Months       | 1 Year               | If Under 2                |                       | 8. Date of Birtl<br>(Month, Day | Vone             |              | 9. Birthp         | lace (State o                               | r Foreign  |
|            | Director   |                     | 217-22-6101 1 M 2 T F 79   | Yrs.              | Morturs                  | Days                 | Hours                     | Min.                  | Sept. 12                        | $\frac{1}{1}$    | 926          | Mary              | y1and                                       |            |
|            | land ow  |                     | Usual Residence of Decedent         10a. State         10b. County         10c. City, To   | wn or Lo          | cation                   |                      |                           |                       |                                 |                  |              | 1                 | 0d. Inside Ci                               | ity Limite |
|            | Mary<br>France   | to                  |  |                   |                          |                      |                           |                       |                                 |                  |              |                   | 1X Yes                                      | •          |
|            | th the<br>or 28g   | lrec                | 10e. Street and Number   |                   | 10f. Zip                 | Code                 |                           |                       |                                 | 10g. Ci          | tizen of W   | /hat Coun         | try?  |            |
|            | ath w  | ral                 | 5100 N. Charles St.  |                   | 21                       | 210                  |                           |                       |                                 | Uı               | nited        | l Sta             | tes   |            |
|            | er de:   | une                 | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  | 13. V             | Vas Deced<br>Yes, spec   | ent of His           | spanic Orig<br>n, Mexican | gin? (Spe<br>, Puerto | cify Yes or No-<br>Rican, etc.) |                  |              | - Americ          |   |            |
| 36         | irs aft  | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 MÃNo If Yes, Give Year or Dates:   | 1                 | ☐ Yes 2                  | M No                 | Specify:                  |                       |                                 |                  | Specify:     | wh                | ite   |            |
| 21215-0036 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther then "netural", or Items 23e or 28e-f show<br>ent, Ite Modisal Eparninar must be notified at  | Completed           | 15. Decedent's Education 16a   | a. Deced          | ent's Usua               | Occupa               | ition                     |                       |                                 | 16b. K           | and of Bu    |                   |   |            |
| 2          | ithin 7  | nple                | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   |                   | kind of wor<br>OO NOT us |                      | uring most                | of workii             | ng                              |                  |              |                   |   |            |
| 2          | iled w<br>tygier<br>her th   |                     | 17 February (First Middle Leas)  | arı               | t tea                    | cher                 |                           |                       |                                 |                  | duca         |                   |   |            |
| and        | d be f<br>antal h<br>red of  | Be c                | 17. Father's Name (First, Middle, Last) Harold Brittingham   |                   |                          |                      |                           |                       | (First, Middle, )<br>Brandt     | Maiden           | Sumame       | e)                |   |            |
| Maryland   | shout<br>nd Me<br>mark   | To                  |  | b. Mailin         | a Address                | (Street a            |                           |                       | Route Number                    | City o           | or Town      | State Zin         | Codel                                       |            |
|            | ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "netural", or Items 23e or 28a-1 show or other traumatic event. Its Modical Examinar must be notified at |                     | 771 1. 0 11 0 1 /1 1.  |                   | Venab.                   |                      |                           |                       | timore,                         |                  |              | 218               | 0000)                                       |            |
| altimore,  | of He of He fitem  |                     | 20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State   |                   |                          |                      |                           | -                     |                                 |                  | ocation - (  |                   | wn, State                                   |            |
| Ē          | . Pages<br>Iment of h<br>tant: ff ite  |                     | `4 □Donation 5 □Other (Specify) Dul Va   | 1 Mer             | n Gard                   | l Mau                | sol De                    | ec. 3                 | 0,2005                          | Ti               | moni         | um, 1             | Mary1a                                      | nd         |
| Bai        | permit. Pages 1 and 2<br>Department of Health a<br>Important: if item 27 is<br>eny Injury or other trea  |                     | 21. Signature of Funeral Service Licensee  | 22.               | Name and Mi              | Address<br>tche      | s of Facility             | edef                  | eld Fur<br>Baltin               | era              | 11 Hc        | me .              | Inc.  |            |
|            | 10200  |                     | 233 Part Enter the disease or complications that caused the death. De  |                   | 65                       | 00 Y                 | ork F                     | Rd.                   | Baltin                          | ore              | , MD         | 21.               |   |            |
|            | Dhurfalan  |                     | 23a. Part Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final | 1                 |                          |                      | 1                         |                       | respiratory arr                 | est,             |              |                   | Approximate<br>Interval Betw<br>Onset and D | veeก       |
| Ì          | Physician<br>/Medical  |                     | disease of condition disease of condition resulting in death)  Due to (or as a consequence   |                   | rvica                    | 1 4                  | -ance                     | <u> </u>              |                                 |                  |              | 3                 | 1/2 yr                                      | \$         |
|            | Examiner   |                     |  | ,-                |                          |                      |                           |                       |                                 |                  |              |                   | ,   |            |
|            | pe sit   | lner                | Sequentially list conditions, if any, leading to immediate cause. Find I III all any is Cause (Disease or injury)  | of):              |                          |                      |                           |                       |                                 |                  |              |                   |   |            |
| ×          | sician and   | Examiner            | Cause (Disease or Injury that initiated events resulting in death) Last  C   | of):              |                          | _                    |                           |                       |                                 |                  |              |                   |   |            |
| 8760,      | ate be executed hysician and the burial-transit  | dical E             | 233.0 (0. 45.2 50.100405.100   | 01).              |                          |                      |                           |                       |                                 |                  |              |                   |   |            |
| Ó          |  | ledic               | 0.   |                   |                          |                      |                           |                       |                                 | To an and        |              |                   |   |            |
| × ox       | death certific<br>e attending p<br>ed for use as   | hysician/Me         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1□Live birth 2 □ Fetal death   | n 3⊡í             | Ectopic pre              | dnancy               |                           |                       |                                 |                  | 23d. Date    | of deliver        | y   |            |
| O. B       | 0 0 0  | sici                | in the past 12 months?  1  Yes 2 No 9  Unknown  1  Unknown   |                   | Other (spe               |                      |                           |                       |                                 |                  | Mont         | h [               | Day Ye                                      | ear        |
| ۵.         | law requires that the as been signed by the 2 should be detached.  | ٥                   | Part II. Other significant conditions contributing to death but not resulting it   | in the un         | darhiina cai             | usa anyo             | n in Part I               |                       | 220 Did tob                     |                  | on contril   |                   |   | -4-0       |
| Records,   | uires tha  | d by                |  | ii iiio uii       | derlyllig cal            | use givei            | THI FAILT.                |                       | 239. Did tot                    | - 5              |              |                   | cause of de                                 |            |
| õ          | iw require<br>been sign<br>should b  | ompleted            |  |                   |                          |                      |                           |                       | 24a. Was ar                     |                  | · ·          |                   | sy findings av                              |            |
| He         | 0 - 0  | omp                 |  |                   |                          |                      |                           |                       | autops                          | /<br>led?        | de           | or to com<br>ath? | pletion of car                              | use of     |
| Vital      | ician: Th<br>certificate<br>rector, pag  | Be C                | 25. Was case referred to medical examiner?   |                   |                          |                      | 26. Place of              | of Death              | 1 Yes 2 (Check only one         | No<br>3)         | 11           | Yes 2             | !LI No                                      |            |
| 0          | hys<br>his<br>il dii   | ပ္                  | 1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou   | utpatient         |                          | _                    | 4   Nurs                  | sing Hom              | e Reside                        | nce 6            | 3 □Other     | (Specify)         |   |            |
|            | fter   | ertification:       | 1 Natural 5 Pending (Month, Day Year)  | Time of<br>Injury |                          | c. Injury a<br>Work? |                           |                       | d. Describe ho                  | w injun          | / occurred   | 4                 |   |            |
| DIVISION   | r Attending<br>er death,<br>rector: After<br>by the fune   | ficat               | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa  | arm stre          | M<br>et factory          | 7.7                  | es 2∐N                    |                       | 3f. Location (Str               | eet an           | d Number     | or Buml           | Pouto Alumba                                |            |
| S          | al or /  | Sert                | 4 Homicide determined building, etc. (Specify)   | 4113, 00100       | oi, ractory,             | OITIOB               |                           | -                     | City or Town                    | State)           | 1 I VUITIOGI | Or Hurar          | noute Numpe                                 | эг,        |
|            | ospital<br>hours a<br>uneral f   | calc                | 29a. Certifying Physician: To the best of my knowledge   | e, death          | occurred at              | the time             | , date and                | place, ar             | nd due to the ca                | use(s)           | and man      | ner as sta        | ed.   |            |
|            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | Medical             | one) and manner stated.  | WOL IUAE          | estigation, ii           | n my apıı            | nion, death               | occurre               | at the time, da                 | te and           | place, an    | d due to t        | he cause(s)                                 |            |
|            | To Too   | Σ                   | 29b. Signature and title of certifier  |                   |                          | License              |                           | 101                   | 29                              |                  | e signed (   |                   | ay, Year)                                   |            |
|            | 10   | -                   | Noter Donlgan  |                   | B                        |                      | 310                       |                       |                                 |                  | 1/28         |                   |   |            |
|            | V  | +                   | 30. Name and address of person who completed cause of death (Item 23a)   | L P               | rint)                    | 54                   | 200                       | 1,100                 | - Balto                         | 1                | 11 -         | 1201              | /   |            |
| •          | Stat   | е                   | 31. Date filed (Month, Day, Year) 33. Registrar's Signature  |                   | 1111 ICS                 | 7).                  | 000                       | MCZ                   | 13010                           | , <sub>[</sub> V | Ud           | 1000              |   |            |
|            | Registra   | ar                  | DEC 2 9 2005   | Spece             | K                        |                      |                           |                       |                                 |                  |              |                   |   |            |

|             |  |                     | For State Registrar   |  | State of  | Marylan                           | -                                       | artmen<br>tificate                      |             |                     |                   |                                 | giene             | <u> </u>              | 2111   |
|-------------|--|---------------------|---|--|---|-----------------------------------|---|---|-------------|---------------------|-------------------|---------------------------------|-------------------|-----------------------|--|
|             | Physici  | an                  | 1. Decedent's Name  |  |   |                                   |   |   |             |                     | , page 1995       | 2. Date of Dea                  | Day               | Year                  | 3. Time of Death                                   |
| . In        | /Medic   |                     | RUTH  | MARIE                                  | MAY   |                                   |   |   | T.          |                     |                   | EMBER                           |                   | 205                   | 12:34 PM   |
|             | Examir   | ier                 | 4a. Fecility Name (#  | not institution,<br>To se oh           | give street and numb<br>Medical                           | er)<br>Cent                       | er                                      | 4b. City,                               | lown, or    | Location of         | of Death<br>WSOTI |                                 | 4c. County        |                       | more   |
|             | 45   |                     | 5. Social Security N  |  |   |                                   | last birthday)                          | If Under                                | 1 Year      | If Under            | 24 Hrs.           | 8. Date of Birt                 | h                 | 9. Birth              | place (State or Foreign                            |
|             | Funeral Director   |                     | 220-18-27   |  | 1 ☐ M 2 🛣 F   | 81                                | Yrs.                                    | Months                                  | Days        | Hours               | Min.              | June 20                         | ), Year)<br>1924  | Cou                   | vland  |
| - 14        | ,  |                     | Usual Residence of  | Decedent                               |   |                                   |   |   |             |                     |                   |                                 |                   |                       |  |
|             | how  | _                   | 10a. State  | 10b. County                            |   |                                   | ty, Town or Lo                          |   |             |                     |                   |                                 |                   |                       | 10d. Inside City Limits 1 ☐ Yes 2 🛣 No             |
|             | Sa-f   | octo                | Maryland  | Balti                                  | more  | Ba.                               | 1timore                                 |   | 0.1         |                     |                   |                                 | 10g. Citizen of V | 1/2 C C C C           |  |
|             | within 72 hours atter death with the Maryland<br>ane.<br>then "natural", or items 23e or 28e-f ehow<br>is Madical Examinar must be notified at   | by Funeral Director | 10e. Street and Nun 6401 N.   |  | Ctmoot  |                                   |   | 10f. Zip                                |             | 212                 |                   |                                 | U.S.              |                       | intr <b>y</b> :                                    |
|             | s 23   | erai                | 11. Marital Status  | Chartes                                | 12. Was Decede  | ent Ever in U                     | .S. 13. 1                               | Was Deced                               |             |                     | igin? (Spe        | cify Yes or No<br>Rican, etc.)  |                   |                       | can Indian,  |
| 10          | riter  | Fun                 | 1 Never Marri   | ed 2□ Marne                            | Armed Forced 1 Tes 2                                      | es?                               | 1                                       |   |             |                     |                   | Rican, etc.)                    |                   | k, White,             | , etc.   |
| 21215-0036  | al', o   | by                  | 3 Widowed   | 4 Divorced                             | If Yes, Give<br>Year or Date                              | 9S:                               |   | 1 ☐ Yes                                 | 2LALNO      | Specify:            |                   |                                 | Specify           | W                     | hite   |
| 5-0         | 72 ho  | Completed           | (Spec   | 15. Decedent's                         | Education<br>grade completed)                             |                                   | 16a. Deced                              | dent's Usua<br>kind of wor<br>DO NOT us | al Occupa   | ation<br>during mos | t of workir       | ng                              | 16b. Kind of Bu   | isiness/fr            | ndustry  |
| 2           | iene.  | m pi                | Elementary/Secon  |  | College (1-4  |                                   | Teach                                   |   |             |                     |                   |                                 | Paroch            | nial                  | Schools  |
|             | filed w<br>Hygier<br>Sther tl  | ő                   | 17. Father's Name (   | First Middle I                         | 5+ yea  | rs                                | Teach                                   | сь, г                                   | MILLI.      |                     |                   | (First, Middle,                 | Maiden Sumam      |                       | Bellootb   |
| Maryland    | ould be fi<br>Mental It<br>arked ot<br>atic ever   | To Be               | Joseph  | 7 1131, 14110010, 2                    | May   |                                   |   |   |             | Soph                |                   | (,,                             | Wills             | -,                    |  |
| Z           | hould<br>id Men<br>marke<br>matic  | ř                   | 19a. Informant's Na   | me/Relationshi                         |   |                                   | 19b. Mailir                             | ng Address                              | (Street a   | -                   |                   | Route Numbe                     | er, City or Town, | State, Zi             | p Code)  |
| <b>∑</b>    | s 1 and 2 should be filed within 72 hours atter death with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "natural", or items 23s or 28s-1 show other traumatic event, ite Misalical Exprinter must be notified at |                     | Sr. Berni   |  |   | ND                                | 6401                                    | N. C                                    | harle       | es St               | reet              | Balti                           | more. Ma          | irvla                 | and 21212  |
| ē,          | f Hearlitern othe  |                     | 20a. Method of Disp   | position                               |   | 20b. F                            | Place of Dispo<br>cemetery, crer        |   |             |                     |                   | ate                             | 20c. Location -   |                       |  |
| E O         | Page<br>lent o<br>nt: if   |                     |   | ☐Cremation :<br>5 ☐ Other (Spe         | 3 □Removal from St<br>ecify)                              |                                   |   |   |             |                     | 12-28             | 8-05                            | Glen Ar           | m, M                  | aryland  |
| Baltimore,  | permit. Pages 1 and 2<br>Department of Health a<br>Importent: if item 27 is<br>eny injury or other tra<br>ance.  |                     | 21. Signature of Fu   | neraf Service Li                       | icensee   |                                   | 22                                      | Name an                                 | nd Addres   | s of Facility       | fe1d              | Funera                          | 1 Home,           | Tnc                   |  |
| <u>m</u>    | 8258   |                     | See   | se / f                                 | erran   | •                                 |   | 6500                                    | Yor         | k_Roa               | id Ba             | altımor                         | e, Mary           | land                  | 21212  |
| <b>S</b>    |  |                     | 23a. Part1. Enter the shock, or hea.                                | ne disease, or c<br>rt failure. List o | complications that cau<br>nly one cause on eac            | ised the deat<br>th line.         | th. Do not ent                          | er the mod                              | le of dying | g, such as          | cardiac o         | r respiratory ar                | rrest,            |                       | Approximate<br>Interval Between<br>Onset and Death |
|             | Physician  |                     | Immediate Cause (<br>disease or conditio<br>resulting in death)     |  | _a SEPTI  | C SHO                             | ICK                                     |   |             |                     |                   |                                 |                   |                       |  |
|             | /Medical<br>Examiner   |                     | resulting in death)   | 1                                      |   | as a consec                       | quence of):<br>RACT I                   | NEEC                                    | TIO         | N.I.                |                   |                                 |                   |                       |  |
| 100         |  | -                   | Sequentially list cor<br>if any, leading to im<br>cause. Enter Unde | nditions,                              | b   | r as a consec                     |   | 141 1                                   | 1 7 01      | 4                   |                   |                                 |                   |                       |  |
|             | tinsit   | ŭ.                  | Cause (Disease or   | infury                                 |   |                                   |   |   |             |                     |                   |                                 |                   |                       |  |
| ,           | te be executed<br>ysician and<br>ie burial-transil   | Examiner            | that initiated events<br>resulting in death) L                      | ast                                    | Due to (or  | as a conseq                       | quence of):                             |   |             | _                   |                   |                                 |                   |                       |  |
| 760,        | ate be executed<br>hysician and<br>the burial-transit  | icai                |   | ,                                      | d   |                                   |   |   |             |                     |                   |                                 |                   |                       |  |
| 99          | leath certiticat<br>attending phy<br>I for use as th   | Med                 | IF FEMALE:  | ·                                      |   |                                   | * |   |             |                     |                   |                                 |                   |                       |  |
| Вох         | ath ce<br>ttendi<br>or use   | lan/                | 23b. Was decedent   |  |   | h 2 Feta                          | aldeath 3□                              | Ectopic pr                              |             |                     |                   |                                 | 23d. Dat<br>Mo    | e of deliv            | rery<br>Day Year                                   |
| 0.          | 0 0 0  | Physician/Med       | 1 ☐ Yes 2¥  |  | 4∐Pregnar<br>9☐ Unknow                                    | nt at time of c<br>n              | leath 5L                                | Other (sp                               | pecify)     |                     |                   |                                 |                   |                       |  |
| <u>α</u>    | requires that the death<br>een signed by the atter<br>rould be detached for r  | Ph                  |   | icant condition                        | s contributing to dea                                     | th but not res                    | sufting in the u                        | nderlying c                             | ause give   | en in Part I        | i.                | 23e. Did to                     | obacco use conti  | ribute to             | the cause of death?                                |
| Records,    | w requires that<br>s been signed t<br>should be deta   | d by                | ACUTE   | RENAL                                  | FAILURE   |                                   |   |   |             |                     |                   | 101                             | Yes 25 No         | 3 Pro                 | bably 4 Unknown                                    |
| Sor         | 0 70   | Completed           |   |  |   |                                   |   |   |             | _                   |                   | 24a. Was                        | an 24b. \         | Nere aut              | opsy findings available                            |
| Re          | e la<br>has  | дшо                 |   | -                                      |   |                                   |   |   |             |                     |                   |                                 | rmed?             | prior to co<br>death? | ompletion of cause of                              |
| Vital       | icien: Th<br>certificate<br>rector, peg  | e Cc                | 25. Was case refer  | red to medicaf                         |   |                                   |   |   |             | 26. Place           | of Death          | 1 ☐ Yes<br>(Check only o        |                   | ☐ Yes                 | 2740   |
| ≥           | Physicien:<br>this certific<br>al director,  | To B                | examiner?<br>1 ☐ Yes 2 ☑  | No                                     | Hospital: 1 1 In  | patient 2                         | ER/Outpatier                            | nt 3 DC                                 | Othe Othe   | ar.                 |                   |                                 | dence 6 Oth       | вг (Ѕрес              | fy)  |
| O           | ding Phys<br>h.<br>Atter this<br>tuneral dir   |                     | 27. Manner of Deat  | h<br>5 🗆 Pending                       | 28a. Date of<br>(Month,                                   | Injury<br>Day Year)               | 28b. Time o                             | 1 2                                     | 28c. Injun  | at                  | 2                 | 8d. Describe                    | now injury occurr | ed                    |  |
| io          | tending (<br>eath.<br>tor: Atter<br>the tuner  | atic                | 2 Accident  | investiga                              | ation   |                                   |   | М                                       |             | Yes 2□              |                   |                                 |                   |                       |  |
| Division of | or Att   | Certification:      | 3 ☐ Suicide<br>4 ☐ Homicide   | 6 Could no<br>determin                 | 288. Flace 0  | f fnjury · At h<br>j, etc. (Speci | ome, farm, str<br>fy)                   | eet, factory                            | y, office   |                     | 2                 | 28f. Location (S<br>City or Tox |                   | er or Rur             | al Route Number,                                   |
| ۵           | lospitai c<br>hours et<br>unerai D<br>ily tilled i   | Ce                  | 22. 2. 4/2.   | Caritain                               | Dhadalaa Tabab  |                                   | and a deat                              |   | -1.15-0.1-0 |                     | d alaca a         | and due to the                  | (a) and           |                       | etata d  |
|             | Hosp<br>24 ho<br>Fune<br>Hely t  | edical              | 29a. Certifier<br>(Check only<br>one)                               | 2 Medical E                            | Physician: To the be<br>exeminar: On the bas<br>and manne | is of examina                     | ation and/or in                         | vestigation                             | , in my of  | oinion, dea         | ith occurre       | ed at the time,                 | date and place,   | and due t             | to the cause(s)                                    |
|             | To the Hospital or Attent within 24 hours etter deatl To the Funeral Director: completely tilled in by the   | Med                 | 29b. Signature and  | title of certifier                     | Λ   |                                   |   | 290                                     | c. License  | e number            |                   |                                 | 29d. Date signed  | 1 (Month,             | Day, Year)   |
|             | P→ > P→ O  |                     | •   | alla                                   | 1   |                                   |   | D                                       | 580         | 444                 |                   |                                 | 12/20             | -11or                 | _  |
|             | i  |                     | 30. Name and addr   | ess of pe son                          | no completed cause  | of death (fter                    | т 23а) (Туре,                           |   |             | , , ,               |                   |                                 | , -               | 1 3                   |  |
| 235         | 1  |                     | CHRISTI   | NE BOU                                 | TZALE.M.  | D                                 | 7601                                    |   | RD          | RIVE                | TOL               | JSON, J                         | MD 212            | 214                   |  |
| 7           |  | ate                 | 31. Date filed (Mon   | th, Day, Year)                         | 2. Reg  | gistrar's Sign                    | ature                                   | K                                       |             |                     |                   |                                 |                   |                       |  |
|             | Regist   | rar                 | UE  | 3 6 3 LU                               | UJ PERSON   | SU NO.                            | 19                                      |   |             |                     |                   |                                 |                   |                       |  |

|  |                 |           | . 1000   | State of Maryland                                      |   |                      |                                  | Mental Hygie                        | ne a m                   | 10110  |
|--|-----------------|-----------|--|--|---|----------------------|----------------------------------|-------------------------------------|--------------------------|--|
|  |                 | 1         | For Stata Registrar  | oraro or many tarre                                    | Certifica                                       |                      |                                  | Rag                                 | C U U I                  | 42112  |
|  | A. 120          |           | I. Decedent's Name (First, Middle, Last                                      | ŋ  |   |                      |                                  | 2. Date of Death                    |                          | 3. Time of Death                                   |
|  | sicia:<br>edica |           | Baby Girl Mallamo  |  |   |                      |                                  | Month<br>CECEMDES                   | Day Yeer 2000            | 5 0359 AM  |
| 110763   | mine            |           | a. Facility Name (If not institution, give                                   | street and number)                                     | 4b. City  | Town, or Lo          | cation of Death                  | Joe Sing.                           | 4c. County of Dea        | ath  |
|  | W.              |           | The Johns Hosp   | okins Hospi-   | tal Ox  | 7 Hi/                | MOLE                             | 1                                   |                          |  |
| Fune<br>Direc  |                 | 5         |  | x 7. Age (In yrs. Ia<br>☐ M 2 日 F                      | Yrs. Months                                     |                      | Under 24 Hrs.<br>Hours Min.<br>2 | 8. Date of Birth<br>(Month, Day, Ye |                          | rthplace (State or Foreign<br>ountry)              |
| 200 E  | tor             | 1         | none Jsual Residence of Decedent   |  |   |                      |                                  | Dec 11, 2                           | 005 MD                   |  |
| nyland   | 5 .             |           | 10a. State 10b. County   | 10c. City  | , Town or Location                              |                      |                                  |                                     |                          | 10d. Inside City Limits                            |
| e Ma   |                 | 2         | MD Harford   | Be1  | Air   |                      |                                  |                                     |                          | 1 ☐ Yes 2X No                                      |
| ING 21215-0036  be filed within 72 hours after death with the Maryland ttal Hygiene. Ad other than "natural", or iteme 23a or 28a-1 show   |                 | Director  | 100. Street and Number   |  | 10f. Zi   | o Code               |                                  | 10g.                                | Citizen of What C        | ountry?  |
| eath v   |                 | 0         | 1233 Athens Court  | 12. Was Decedent Ever in U.S                           |   | 014                  | anio Origina (Sr                 | poorty Vos or No                    | USA<br>14. Race - Am     | origan Indian                                      |
| fter d   |                 | ם ב       | Marital Status     Never Married 2 Married                                   | Armed Forces? 1 ☐ Yes 2 ☒ No                           | If Yes, spe                                     | cify Cuban, N        | Mexican, Puerto                  | ecify Yes or No-<br>Rican, etc.)    | Black, Wh                | te, etc.   |
| U3C<br>urs a   |                 | 2         | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:                         | 1 🗆 Yes   | 2 <b>⊠</b> No S      | Specify:                         |                                     | Specify: wh:             | ite  |
| 72 hc  |                 | Completed | 15. Decedent's Edu<br>(Specify only highest grad                             | ucation<br>de completed)                               | 16a. Decedent's Usu<br>(Give kind of we         | ork done durir       | n<br>ng most of work             | ring 161                            | . Kind of Business       |  |
| within 72<br>Bne.  | 0               | 1         | Elementary/Secondary (0-12)  | College (1-4or 5+)                                     | life. DO NOT u                                  | se retired)          | •                                |                                     |                          |  |
| G 2<br>filed v<br>Hygie<br>other t   |                 |           | none n<br>7. Father's Name (First, Middle, Last)                             | one  | none  | . 18                 | Mother's Nam                     | e (First, Middle, Mai               | ne                       |  |
| Iryland<br>should be file<br>of Mentat Hy<br>marked oth  |                 |           | ,  |  | unk   |                      | Trista N                         |                                     |                          |  |
|  |                 | - 1       | 19a. Informant's Name/Relationship (T)                                       | ype, Print)  | 19b. Mailing Addres                             | s (Street and        | Number or Rui                    | al Route Number, C                  | ity or Town, State,      | Zip Code)  |
|  |                 |           | Johns Hopkins Hos  | pital  | 600 N. Wo                                       | lfe St               | reet Ba                          | ltimore.                            | MD 21287                 |  |
| Baltimore, Department of Hea mportant: If Item   | 5               | 2         | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F                    | co   | ace of Disposition (Na<br>imetery, crematory or | me of                |                                  |                                     | Location - City or       | Town, State  |
| Pages ment of ant: If it   | 2               |           | 4 Donation 5 Dother (Specify)  |  |   |                      |                                  |                                     |                          |  |
| Baltimol permit. Pages Department of important: If i   | once.           |           | 21. Signature of Funeral Service Licens  Ronald S. V                         | Jad & Wirektor   |   | Anator               |                                  | J 655 TT 1                          | 0 - 1 4 '                |  |
|  | a               | 4         | 23a. Part Enter the disease, or comp   | TOINE  | Dalli   | nore.                | MD / L/U                         | d 655 W. 1                          |                          | T  |
|  |                 |           | shock or heart failure. List only o  | ne cause on each line.                                 | 1 1   | /                    | uch as cardiac                   | or respiratory arrest,              |                          | Approximate<br>Interval Between<br>Onset and Death |
| Physici<br>/Medi   | _               | i         | Immediate Cause (Final disease or condition resulting in death)              | a EXTREME  | PREMATA   | eity                 |                                  |                                     |                          | 226/7  |
| Examir   |                 |           |  | Due to (or as a consequ                                | ence of);                                       | /                    |                                  |                                     |                          |  |
|  | * 1. 18         | 5         | if any, leading to immediate   | b. Due to (or as a consequent                          | ence of):                                       | -                    |                                  |                                     |                          |  |
| cuted  |                 |           | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | C  |   |                      |                                  |                                     |                          |  |
| 760,<br>te be executed<br>ysician and  |                 |           | resulting in death) Last   | Due to (or as a consequent                             | ence of):                                       |                      |                                  |                                     |                          |  |
| . Box 68760, death certificate be executed e attending physician and   | _   =           | 200       | •  | d  |   |                      |                                  |                                     |                          |  |
| Box 687 leath certificate attending phys   | 20 00           |           | IF FEMALE:   | 23c. If yes, outcome of pregnan                        | ncv   |                      |                                  |                                     |                          |  |
| BOX<br>eath cert<br>attendin   | 5               |           | in the past 12 months?   | 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of de | death 3 ☐ Ectopic p                             |                      |                                  |                                     | 23d. Date of de<br>Month | livery<br>Day Year                                 |
| at the de by the a   |                 | 2         | 1 Yes 2 No<br>9 Unknown  | 9☐ Unknown   |   |                      |                                  |                                     |                          |  |
| - E 99   |                 | r y       | Part II. Other significant conditions co                                     | ntributing to death but not resul                      | Iting in the underlying                         | ause given ir        | n Part I.                        | 23e. Did tobac                      | co use contribute t      | o the cause of death?                              |
| Hecords, P he law requires that e has been signed b  |                 |           |  |  |   |                      |                                  | 1 ☐ Yes                             | 2 € No 3 □ P             | robably 4 □Unknown                                 |
| tawre<br>as be   |                 | Completed |  |  |   |                      |                                  | 24a. Was an autopsy                 | 24b. Were a              | utopsy findings available completion of cause of   |
|  | Page 1          | 5         |  |  |   |                      |                                  | performed                           | ? death?                 | 2 No   |
| VITAL P<br>sician: Th<br>certificate   | 5 6             | ט :       | 25. Was case referred to medical examiner?                                   | U  |   |                      | S. Place of Deat                 | h (Check only one)                  |                          |  |
|  | K '             |           | 1 ☐ Yes 2 ☑ No ☐ ☐   |  | ER/Outpatient 3□ D                              |                      |                                  | me 5 Residence                      |                          | ocify)   |
| DIVISION OF i or Attending Phy after death. Director: After this   |                 |           | 1 ☐ Matural 5 ☐ Pending  | (Month, Day Yeer)                                      | 28b. Time of Injury                             | 28c. Injury at Work? | 2 🗆 No                           | 28d. Describe how i                 | njury occurred           |  |
| DIVISIO  si or Attendi after death.  Director: A   | 100             | 2         | 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of Injury - At hon                          |   |                      |                                  | 28f Location (Street                | and Number or R          | ural Route Number.                                 |
| Div.   |                 |           | 4  Homicide determined   | building, etc. (Specify)                               | ) =   | ,,                   |                                  | City or Town, S                     | tate)                    |  |
| ospite<br>hours<br>unere   |                 |           | 29a. Certifier 1 Certifying Phy  | rsician: To the best of my know                        | riedge, death occurred                          | at the time, o       | date and place,                  | and due to the cause                | e(s) and manner a        | s stated.  |
| DIVISION  To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attended willing in by the funer computative filled in by the funerent or the fun |                 | 2000      | Une/   | iner: On the basis of examination and manner stated.   |   |                      |                                  |                                     |                          | o to the cause(s)                                  |
| Tot  | 3               | 2         | 29b. Signature and title of certifier  |  | 29  | c. License nu        | ımber                            | 29d.                                | Date signed (Moni        | h, Day, Year)                                      |
|  |                 |           | account of   | umer MO  |   | KES                  | -000                             | 12                                  | 111/05                   |  |
|  |                 | T         | 30. Name and address of person who co<br>Edward Tanner, 6                    | ompleted cause of death (Item.                         | 23a) (Type, Print)                              | 2003 - 1             | ala.                             | 1/2 1/ -                            | 171.60                   |  |
| was a  | State           |           | 31. Date filed (Month, Day, Year)  | 32. Aegistrar's Signatu                                | JT Mark   | proper               | , 11144                          | IGNO 2                              | 168/                     |  |
| Reg  | gistra          |           | DEC 2 9 2  | UUS ASSESSED A   | 2 Marie   |                      | 1                                |                                     |                          |  |

|        |                               |   |                  | State of Maryland / Department of Health and Mental Hygiene 15 42 1 3  Certificate of Death Reg. No.  |
|--------|-------------------------------|---|------------------|---|
|        |                               | Physici   |                  | 1. Decedent's Name (First Middle, Last)  2. Date of Death  Month  Day  Year  1. Decedent's Name (First Middle, Last)  And Month  Day  Year  1. Decedent's Name (First Middle, Last)   |
|        |                               | /Medio<br>Examir  | Sec.             | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. Country of Death  |
|        |                               | Funeral<br>Director   |                  | 5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  9. Birthplace (State or Foreign Country)  Yrs. Months Days Hours Min. July 4. 1916  9. Birthplace (State or Foreign Country)  Waryand  1 Usual Residence of Decedent   |
|        |                               | death with the Maryland<br>ms 23s or 28s-f show<br>f must be notified at                                    | ctor             | 10a. State NA. 10b. County NA Baltemore 10d. inside City Limits   |
|        |                               | th with the 23a or 28   | Funeral Director | 10e. Street and Number Apt; 612 10f. Zip Code 10g. Citizen of What Country? USA   |
|        | 980                           |   | þ                | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  16. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  17. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, Specify Cuban, Mexican, Puerto Rican, etc.)  18. Race - American Indian, Black, White, etc.  19. Specify: Cuban, Mexican, Puerto Rican, etc.) |
|        | altimore, Maryland 21215-0036 | e filed within 72 hours after<br>al Hygiene.<br>I other than "natural", or Ite<br>vent, ire Medical Evanire | Completed        | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or5+)  AND A  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  City Hospital  City Hospital   |
|        | land 2                        | ild be filed<br>ental Hygiked other<br>ic event.  | To Be C          | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  None of the Last  |
| 2.7    | Mary                          | and 2 should be fastly and Mental P<br>n 27 ie marked of<br>ier traumatic ever                              | -                | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Findia, 1851/Sm - granddgt, 3107 Aspen Cf. Balto, md, 21227  |
| 3.4M   | more,                         | Pages 1 and 2 nent of Health int: if item 27 inty or other tra  | -                | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Dogation 5 Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  Netro Cremitory Jan. Z. 2006  To Still Mod.   |
| .51    | Balti                         | permit. Pages. Department of Inportant: if ite eny injury or of   |                  | 21. Signature of Funeral Service Cicentral  22. Name and Address of Facility Canada 54, 21229  Millela M. Chillage Markey Wallace tuneral series better me.   |
| 9      |                               | Physician   |                  | 23a. Part. Enterfor disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory arrest, shock of natifallure. List only one cause on each line.  Immediate Caus (Final disease or condition  Fud Stend Remot Disease.   |
|        |                               | /Medical<br>Examiner  |                  | Due to (or as a consequence of):  |
| 105    | 1                             | rcuted<br>nd<br>transit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in ideath) Last  b. Due to (or as a consequence of):  |
| 127    | 8760,                         | icate be executed<br>physicien and<br>s the burial-transit  | dical Ex         | Due to (or as a consequence of):  d   |
| 15     | O. Box 6                      | death certif<br>e attending<br>od for use as  | Physiclan/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  |
| (tid   | ds, P.                        | w requires that the de<br>been signed by the<br>should be detached  |                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Highnown  |
| MUR PH | Division of Vital Records,    | The la  | Completed by     | 24a. Was an autopsy findings available autopsy performed? 1   |
| 4      | of Vita                       | Physician: Th<br>this certificate<br>al director, pag   | To Be (          | 25. Was case referred to medical examiner?  1  Yes 2 No   |
| 511    | sion c                        | ding<br>After<br>funes  | Certification:   | 27. Mann of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be  28a. Date of Injury 28b. Time of Injury Work?  M Yes 2 No  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  |
| W      | DIV                           | Hospitsi or Att<br>4 hours after d<br>Funerai Direct<br>tely filled in by i                                 | Certific         | 4 Homicide determined building, etc. (Specify)  |
|        |                               | the single  | Medical          | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |
|        |                               | or con  |                  |   |
|        |                               | 'h  |                  | Number of person who completed cause of death (Item 23a) (Type, Print)  Devid h-Knox, 9 W. Like Ave. Bulking MD a 1210-1303   |
|        |                               | Sta<br>Regist   |                  | 31. Date filed (Month, Day, Year) DEC 2 9 2005  22. Registrar's Signature   |

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Vear Month **Physician** 3,00 ? M Evelyn Carolyn Potock 2005 26 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Agnes St Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

Months | Davs | Hours | Min. (Month, Day, Year) Social Security Number UNK . 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 62 Director AUG 18, 1943 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State or 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No Director Marvland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 900 S. Rolling Road 21228 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status 14. Race - American Indian. Black, White, etc. X ↑ Never Married 2 Married 1 Yes 2 No If Yes, Give Y Year or Dates: 1 ☐ Yes 2 No White Baltimore, Maryland 21215-0036 Specify: Specify. 3 Widowed 4 Divorced 'natural', Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.

Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "ne eny injury or other traumatic event, the Mealth once. Elementary/Secondary (0-12) College (1-4or 5+) Clothing Store 11 Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Martin Potock Caroline Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian McColskey/Sister 3 Pinder Avenue Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 3 ☐ Other (Specify) 12/29/05 Baltimore, MD Metro Crematory. Inc. 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility Cremation Society of MD, Inc. Cremation So 299 Frederick Road Baltimon 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition **Physician** Multiorgan Overwhelming /Medical resulting in death) Due to (or as a consequence at) Examiner Peritonitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Sigmoid perforation Due to (or as a consequence of) ate has been signed by the ettending physicien page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Potock, Evelyn þ 1 Yes 2 No 3 Probably 4 Unknown Pulmoner, Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier Surgical resident, H.D. 9-18205 27,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Ave, Baltimore, MD 21229 Kashi-31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 2 9 2005 Registrar

| 1 - For State Registrar  | State of Maryland  |                                    | rtment of H                              |   | lental Hygie  | こししつ  | 42115  |
|--|--|------------------------------------|--|---|---|---|--|
| Decedent's Name (First, Middle, L     Physician  |  |                                    |  |   | 2. Date of Death<br>Month                                       | Day 27 200  | 3. Time of Death 5 1.50 A M                        |
| /Medical Calvin Examiner 4a. Facility Name (If not institution, gr   | we street and number)  |                                    | Parker 4b. City, Town, or                | Location of Death   | December  | 4c. County of Deat  |  |
| Funeral 5. Social Security Number 6.   | Sex 7. Age (In yrs. In   | CN+Cr<br>ast birthday)<br>Yrs.     | If Under 1 Year<br>Months Days           | Bunic<br>If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth<br>(Month, Day, Ye                             | ear) Co   | hplace (State or Foreign unity)                    |
| Director 214-38-4200 Usual Residence of Decedent   | 81   | 113.                               |  |   | May 27,1  | 924   Nor   | th Carolina  |
| Toa. State 10b. County  Maryland Anne A  10e. Street and Number  24 West Furnace  11. Marital Status   |  | n Burn                             |  |   |   |   | 10d. Inside City Limits<br>1 ☐ Yes 2 ☑ No          |
| Maryland Anne A  |  |                                    | 10f. Zip Code                            |   | 10g.  | Citizen of What Co  | ountry?  |
| 1 Never Married 2 Married  | Branch Road  12. Was Decedent Ever in U.S Armed Forces?  1   |                                    | 2106 Vas Decedent of H Yes, specify Cuba | 1<br>ispanic Origin? (Sp<br>in, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)                                | U.S.A  14. Race - Ame Black, White                        | ncan Indian,                                       |
| DO TO THE WATER OF | Year or Dates:   |                                    | ent's Usual Occup                        |   | 161   | Who. Kind of Business/                                    | lodusto  |
| Elementary/Secondary (0-12)  | rade completed)  College (1-4or 5+)  | (Give k<br>life. Di                | ind of work done on NOT use retired      | during most of work<br>()                                   | ing   |   |  |
| N 5 8 4 5 6 6 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6 7 6  |  | Master                             | Chief H                                  | ospital C<br>18. Mother's Nam                               | orpsman<br>e (First, Middle, Mai                                | U.S. Na<br>den Surname)                                   | V.Y.   |
|  | Issac  | Park                               |  | Mary  | Li11  |   | regory   |
| Warren  19a. Informant's Name/Relationship  June L. Parker (  20a. Method of Disposition   |  |                                    | `  |   | a <i>l Route Number, Ci</i><br>h Road G1                        |   | Zip Code)<br>2, MD 21061                           |
|  | 20b. PI  | lace of Disposi                    |  |   |   | c. Location - City or                                     |  |
| 20a. Method of Disposition  1  | ify) Ar1   | ington                             | Nat. Cer                                 | m. 2/15   | /06 A   | rlington  | Virginia   |
| and and and and and and and and and and  | Min  | Mo<br>3:                           | cCu11y-P<br>204 Moun                     | olyniak F<br>tain Road                                      | uneral Ho<br>Pasadena   | me. P.A.<br>, Marylan                                     | d 21122  |
| 23a. Part1. Enter the disease, or conshock, or heart failure. List only  | mplications that caused the death y one cause on each line.  | . Do not enter                     | r the mode of dyin                       | g, such as cardiac  | or respiratory arrest,  |   | Approximate<br>Interval Between<br>Onset and Death |
| Physician Immediate Cause (Final disease or condition resulting in death)  | a. Due to (or as a consequ   | JGEV<br>Jence of):                 | uc 8V                                    | wcic_   | 1 1   |   | Days   |
| Examiner  Sequentially list conditions,  | b. Due to (or as a consequ   | d (                                | Cordin                                   | omyo  | athy  | 1   | Months   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a consequ  | rence or).                         |  | /   |   | 7   |  |
|  | Due to (or as a consequ  | uence of):                         |  |   |   |   |  |
| ob / itilicate as the as the ledle.  | d  |                                    |  |   |   |   |  |
| The law requires that the death certificate as the the the spen signed by the attending physical part of the attending physical part of the attending physical part of the attending physical part of the attending physical part of the attending physical part of the attending physical part of the | 23c. If yes, outcome of pregnar<br>1□Live birth 2□Fetal<br>4□Pregnant at time of de<br>9□Unknown   | death 3 E                          | Ectopic pregnancy<br>Other (specify)     |   |   | 23d. Date of deli<br>Month                                | ivery<br>Day Year                                  |
| Part II. Other significant conditions  | contributing to death but not resu   | ulting in the und                  | derlying cause give                      | en in Part I.   |   |   | the cause of death?                                |
| law requires to the requires to the requires to the requires to the requires to the requires to the requires to the requires to the requirement of | ephotopo   | yrus                               |  |   | 1 Yes   |   |  |
|  |  |                                    |  |   | 24a. Was an autopsy performed                                   | prior to death?   | topsy findings available completion of cause of    |
| 25. Was case referred to medical examiner?   | Hospital:  |                                    | all post Oth                             |   | h (Check only one)  |   |  |
| 27. Manger of Death  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury             | 28c. Injur                               | 4   Nursing Ho  | me 5 Residence<br>28d. Describe how i                           |   | cify)  |
| DIVIDIO   1   1   2   2   2   2   2   2   2   2  |  |                                    | _  |   |   |   |  |
| A Homicide   | be Igo Place of town. At he  | ime, farm, stre                    | et, factory, office                      |   | 28f. Location (Stree<br>City or Town, S                         | t and Number or Ru<br>itate)                              | ıral Route Number,                                 |
| To Manner of Death  Ye hours et each  Ye hours e | be 28e. Place of Injury - At ho building, etc. (Specify)  Physician: To the best of my know aminer: On the basis of examinat               | viedge, death                      | occurred at the tin                      |   | City or Town, S   | e(s) and manner as  | stated.  |
| A Homicide  A Certifying 14 Control of the Fundament of t | be 28e. Place of Injury - At ho building, etc. (Specify  | viedge, death                      | occurred at the tin                      | pinion, death occur   | City or Town, S<br>and due to the caus<br>red at the time, date | e(s) and manner as  | stated.<br>to the cause(s)                         |
| sympoly 2 unity in the control of th | 28e. Place of Injury - At he building, etc. (Specify Physician: To the best of my know aminer: On the basis of examinat and manner stated. | wledge, death<br>klion and/or inve | occurred at the timestigation, in my o   | pinion, death occur<br>e number                             | City or Town, S and due to the caused at the time, date         | e(s) and manner as and place, and due  Date signed (Monti | stated. to the cause(s)                            |
| sympoly 2 unity in the control of th | be 28e. Place of Injury - At ho building, etc. (Specify)  Physician: To the best of my know aminer: On the basis of examinat               | wledge, death<br>klion and/or inve | occurred at the timestigation, in my o   | pinion, death occur<br>e number                             | City or Town, S<br>and due to the caus<br>red at the time, date | e(s) and manner as and place, and due  Date signed (Monti | stated. to the cause(s)                            |

|                     |  |                  | For<br>State<br>Registrar   | State of Ma   | arylan           | nd / Depa                        | artment<br>rtificate                       | of H                   | ealth a                    | and M                   | lental Hy                            | /giệne)<br>Reg. No.        | 05                                | 42116   |
|---------------------|--|------------------|---|---|------------------|----------------------------------|--|------------------------|----------------------------|-------------------------|--------------------------------------|----------------------------|-----------------------------------|---|
| 8                   | Physicia   | an               | 1. Decedent's Name (First, Middle, La   | st)   |                  | -                                | ,  | 1                      | /                          |                         | 2. Date of D<br>Month                | eath<br>Day                | Year                              | 3. Time of Death                                      |
|                     | Physici<br>/Media  |                  | Forth   | BOWN  |                  |                                  | p  | (U)                    | rist                       |                         | Decem                                | 1 "                        | 21,2005                           | 14:13 M   |
|                     | Examir   | ner              | 4a. Facility Name (If not institution, giv  | street and number)  | 1                | 11                               | 4b. City, T                                | Town, or               | Location of                | of Death                |                                      | 4c. C                      | ounty of Dea                      | th  |
| 20                  |  |                  | The Johns Hop   | Kins H  | OSP.             | tal                              | 109  | 1/10                   | noc                        | Z                       |                                      |                            |                                   |   |
|                     | Funeral<br>Director  | þ                |   | ex 7. Age   | e (In yrs.<br>85 | iast birthday)<br>Yrs.           | If Under 1<br>Months                       | 1 Year<br>Days         | If Under                   | Min.                    | 8. Date of Bi<br>(Month, D<br>03/01) | 71920                      | 9. Bir<br>Vas                     | thplace (State or Foreign<br>country)<br>shington, DC |
|                     | land<br>ow   |                  | 10a. State 10b. County  |   | 10c. Cit         | ly, Town or Lo                   | cation                                     |                        |                            |                         |                                      |                            |                                   | 10d. Inside City Limits                               |
|                     | Man  | ţo               | MD Montgome   | ery   | Sil              | lver Sp                          | oring                                      |                        |                            |                         |                                      |                            |                                   | 1 ☐ Yes 2 XNo   |
|                     | r 28s  | irec             | 10e. Street and Number  |   | 1                |                                  | 10f. Zip (                                 | Code                   |                            |                         |                                      | 10g. Citize                | n of What Co                      | ountry?   |
|                     | h witi   | ai D             | 3160 Gracefield H   | Road  |                  |                                  | 209  | 04                     |                            |                         |                                      | USA                        |                                   |   |
|                     | 72 hours after death with the Maryland<br>"natural", or Itama 23a or 28a-f ahow<br>idigal Exertainer intel be revilled at                            | Funeral Director | 11, Maritat Status  | 12. Was Decedent I<br>Armed Forces?                                 | Ever in U        | .S. 13.                          | Was Decede                                 | ent of His             | spanic Orig                | gin? (Spe               | ecify Yes or N<br>Rican, etc.)       | 0- 14                      | . Race - Ame                      |   |
| 9                   | or Itu   |                  | 1 Never Married 2 Married   | 1 ☐ Yes 2(X)<br>If Yes, Give  | No               |                                  | 1 ☐ Yes 2                                  |                        | Specify:                   | i, rueito               | rican, etc.)                         |                            | Black, Whit                       |   |
| 90                  | n 72 hours<br>"natural",   | d by             | 3XXWidowed 4 □ Divorced   | Year or Dates:  |                  |                                  |  |                        |                            |                         |                                      | 3                          | pecify: W                         | nite  |
| 21215-0036          |  | Completed        | 15. Decedent's Ed<br>(Specify only highest gra  |   |                  | 16a. Dece<br>(Give               | dent's Usual<br>kind of work<br>DO NOT use | Occupa<br>k done d     | tion<br>uring most         | of works                | ng                                   | 16b. Kind                  | of Business                       | /Industry   |
| 12                  | l within<br>liene.<br>r than "   | m<br>d           | Elementary/Secondary (0-12)   | College (1-4or 5  | i+)              | Teac                             |  | e reti <b>re</b> a)    |                            |                         |                                      | Monte                      | essori                            | School School   |
|                     | TO 12 14 11 11   |                  | 12<br>17. Father's Name (First, Middle, Last)   | · · · · · · · · · · · · · · · · · · ·                               |                  | Teac.                            | 161  |                        | 18. Mothe                  | r's Name                | (First, Middle                       |                            |                                   |   |
| Maryland            | d 2 should be filed in and Mental Hyg<br>7 Is marked other traumatic avant,  | o Be             | Abe Botkin  |   |                  |                                  |  |                        |                            |                         | shoff                                | s, maiden on               | inamo,                            |   |
| $\overline{\Sigma}$ | should be<br>and Mental<br>is marked of<br>sumatic av  | 2                | 19a. Informant's Name/Relationship (  | Type, Print)  |                  | 19b. Mailir                      | ng Address                                 | (Street a              |                            |                         | I Route Numb                         | er. City or 7              | own. State.                       | Zip Code)   |
|                     | nd 2 state at trau   |                  | Steven Rubin  |   |                  | 8627                             |  |                        |                            |                         |                                      |                            |                                   | ty, MD 21043  |
| ā,                  | He He  |                  | 20a. Method of Disposition  |   | 20b. P           | Place of Dispo<br>cemetery, crea | sition (Name                               | e of                   |                            |                         | ate                                  | 20c. Loca                  | tion - City or                    | Town, State   |
| Ë                   |  |                  | 1 ☐ Burial 2XXCremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specifi  |   |                  | tro Cr                           |  |                        | " [1                       | 2/27                    | /2005                                | Cator                      | sville                            | e, MD   |
| Baltimore,          | permit. Pag<br>Department<br>Important: I<br>any injury o  |                  | 21. Signature of Funeral Service Licer  | see ( ) C M Car   |                  | 22                               | Name and                                   | Addres                 |                            | WIL                     | zke Fu                               | neral<br>Columb            | Homes                             | , Inc.<br>D 21045                                     |
| -gr                 | - a.S.   |                  | 23a. Part1. Enter the disease, or com   | plications that caused  | the deati        |                                  |  |                        |                            |                         |                                      |                            | ) La, 11.                         | Approximate   |
|                     | Physician  |                  | shock, or heart failure. List only<br>Immediate Cause (Final  | one cause on each in  | 10.              |                                  | mark                                       | 715.                   |                            |                         |                                      |                            |                                   | Interval Between<br>Onset and Death                   |
| 1                   | /Medical   |                  | disease or condition resulting in death)  | a. / IC>VIR   | a conseq         | ughce of):                       | onga                                       | 113/11/                | VIE.                       |                         |                                      |                            |                                   | 1 WEEK  |
|                     | Examiner   |                  | Conventiathy list conditions  | · PARUE   | non              | 19                               |  |                        |                            |                         |                                      |                            |                                   | 1 month   |
| 8                   | D =  | Der              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Doe to (or as   | a conseq         | uence of):                       |  |                        |                            |                         |                                      |                            |                                   | ,,,   |
| 1                   | ecute<br>ind<br>trans  | Examiner         | triat initiated events  | c   |                  |                                  |  |                        |                            |                         |                                      |                            |                                   |   |
| 50,                 | be executed<br>sicien and<br>burial-transit  |                  | resulting in death) Last  | Due to (or as   | a conseq         | uence of):                       |  |                        |                            |                         |                                      |                            |                                   |   |
| 8760,               | physic   | dical            | •   | d   |                  |                                  |  |                        |                            |                         |                                      |                            |                                   |   |
| 9 x                 | n certific<br>anding p<br>use as   | Physician/Medi   | IF FEMALE:  | 23c. If yes, outcome  | of pregna        | Incv                             |  |                        |                            |                         |                                      |                            |                                   |   |
| Вох                 | atten<br>for u   | cian             | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live birth 4 ☐ Pregnant at                                      | 2 Feta           | Ideath 3                         | Ectopic pre                                |                        |                            |                         |                                      | 23                         | <li>d. Date of del<br/>Month</li> | ivery<br>Day Year                                     |
| o.                  | by the destached   | ysi              | 1 □ Yes 2 □ No<br>9 □ Unknown   | 9□ Unknown  |                  | ou J_                            | J Other (Spe                               | Ciry)                  |                            |                         |                                      |                            |                                   |   |
| <b>Q</b>            | that   | by Pł            | Part II. Other significant conditions of  | ontributing to death bu   | ut not resi      | ulting in the u                  | nderlying car                              | use give               | n in Part I.               |                         | 23e. Did                             | tobacco use                | contribute to                     | the cause of death?                                   |
| of Vital Records,   | law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit | q pe             |   |   |                  |                                  |  |                        |                            |                         | 10                                   | Yes 2                      | √0 3 □ Pr                         | obably 4 Unknown                                      |
| 00                  | law re   | Completed        |   |   |                  |                                  |  |                        |                            |                         | 24a. Was                             | an :                       | 24b. Were au                      | itopsy findings available                             |
| æ                   | cate ha  | E                |   |   |                  |                                  |  |                        |                            |                         |                                      | ormed?                     | prior to death?                   | completion of cause of                                |
| ta                  | rtifica  | 0                | 25. Was case referred to medical  |   |                  |                                  |  | 12/20/20               | 26. Place                  | of Death                | Check only                           | 2 ⊡No<br>onel              | T Tes                             | 2□ No   |
| <b>1</b>            | Physician:<br>this certific<br>ral director,   | To B             | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital: 1 Inpatie   | nt 2 🗆           | ER/Outpatien                     | t 3 DOA                                    | Othe                   | r                          |                         | ne 5∐Resi                            |                            | Other (Spe                        | cify)   |
| 0                   |  |                  | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injur<br>(Month, Day                                   | y<br>Year)       | 28b. Time of<br>Injury           | 28   | c. Injury<br>Work      |                            |                         | 8d. Describe                         |                            |                                   | ./  |
| 0                   | Attending<br>ir death.<br>actor: After<br>by the fune  | atic             | 2 ☐ Accident investigation  |   |                  |                                  | м  |                        | es 2 🗆 N                   | No                      |                                      |                            |                                   |   |
| Division            | or Att   | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Inju-<br>building, etc                                |                  |                                  | eet, factory,                              | office                 |                            | 2                       | 8f. Location (<br>City or To         | Street and I<br>wn, State) | lumber or Ru                      | iral Route Number,                                    |
|                     | urs a  |                  |   |   |                  |                                  |  |                        |                            |                         |                                      |                            |                                   |   |
|                     | To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by   | edical           | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exan   | ysician: To the best on<br>hiner: On the basis of<br>and manner sta | examina          | wledge, death<br>tion and/or inv | occurred at<br>estigation, i               | t the time<br>in my op | e, date and<br>inion, deat | d place, a<br>h occurre | ind due to the<br>ad at the time,    | cause(s) ar<br>date and pl | id manner as<br>ace, and due      | stated.<br>to the cause(s)                            |
|                     | To the within 2 To the complet   | Me               | 29b. Signature and title of centur  |   |                  |                                  |  | License                |                            |                         |                                      |                            | igned (Monti                      |   |
| •                   | $\sim$   |                  | 100   | m.  | D.               |                                  | R  | 25                     | - 00                       | 0                       | \ \frac{1}{2}                        | 1002                       | nh 50                             | 22 2005   |
|                     | 17   |                  | 30. Name and address of person who  |   |                  |                                  | Print)                                     | 1                      | ./                         | 1                       | //                                   | 1/                         | 10.                               | 22,2005   |
|                     |  |                  | HENRY BOATENG   | M.D. 600<br>32. Registra  | 14.              | WOLF                             | e St                                       | REG                    | H                          | DA                      | 110,11                               | 1d = 1                     | 1487                              | <b>′</b>  |
|                     | Sta<br>Registr   | -                | 31. Date filed (Month, Day, Year) DEC 2 9 2005  | 32. Hegistra  | ii s oigna       | joset                            |  |                        |                            |                         | ,                                    |                            |                                   |   |

Amend item/8, perfil 351, 1/18/06 II State of Maryland / Department of Health and Mental Hygiene 55 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** December 25th 2005 Kossman Josephine 1:15 DM /Medical 4a. Facility Name (If not institution, give street and number)
Howard County General Hospital 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 3/2/1925 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 1 E Yrs. Director 007-38-7030 80 Poland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or itams 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Carrol1 Marriottsville Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21104 881 Marriottsville Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) School System Lunchroom Manager 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fift Department of Health and Mental Hy Important: if Itam 27 is marked oth any july or othar traumatic evan 2008. Be Joseph Maslanka Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 881 Marriottsville Road Marriottsville, MD 21104 (Daughter) Rose Ann Craig 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State Sunset Gardens ~01/04/2006 Thonossassa, FL \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Home, Inc.
5555 Twin Knolls KoadColumbia, Maryland 21045 21. Signature of Funeral Service Licensee Selendole . 3a. Part1. Enter the disease, or complications that caused to death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dune Approximate Interval Between Onset and Death Immediate Cause (Final nticemia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner eumonia Sequentially list conditions, in any, leading to miniscillate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day ò Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.0. should be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, lindro cestralis essine 3 ☐ Probably 4 ☐ Onknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 has 2 D No 1 ☐ Yes or Attanding Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🖆 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funarai Diractor: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Funa completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie D50870 5005 Signal Bell lane Clarinille M) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUCS SIGN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 15

|                   |   |                  | For State   | State of Maryland  |  | nt of Health and te of Death                                  |   | C 000                            | 42118  |
|-------------------|---|------------------|---|--|--|---|---|----------------------------------|--|
|                   |   |                  | Registrar  1. Decedent's Name (First, Middle, La.   |  |  | le or Dealir  | Reg.                                      | 4.5                              | 3. Time of Death                                   |
|                   | Physici<br>/Medic   |                  | PHYLLIS   | BINSO  | M  |   | December                                  | Day 14, Year 25 2005             | 6.05p.M  |
|                   | Examir  |                  | 4a. Facility Name (If not institution, give<br>Northwest  | street and number)   | $\mathcal{J}$  | Town, or Location of Dea                                      | re  | 4c. County of Death              |  |
|                   | Funeral<br>Director   | 2                | D 00 6001   | ex<br>□ M 2 XF 7. Age (In yrs. Ja  | Yrs. If Under  | Days Hours Mir  |   | 51 Ba                            | place (State or Foreign<br>intry)                  |
|                   | yland   |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. City  | , Town or Location                                     |   |   |                                  | 10d. Inside City Limits                            |
|                   | Ba-f et   | ctor             | MO  | Be   | Utimo  | re  |   |                                  | 1 Yes 2 No   |
|                   | 3a or 2   | Funeral Director | 1201 S-Hawc   | Wer Street   | L 101.2  | 0/230   | 10g.                                      | Citizen of What Cou              | untry?   |
|                   | ome 2   | ınera            | 11. Marital Status  | 12. Was Decedent Ever in U.S<br>Armed Forces?  | S. 13. Was Dec   | edent of Hispanic Origin? (.<br>ecify Cuban, Mexican, Pue     | Specify Yes or No-<br>rto Rican, etc.)    | 14. Race - Ameri<br>Black, White |  |
| 5-0036            | iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 is marked other than "naturel", or Iteme 23e or 28e-f ehow or other traumatic event, Ita Medical Examinar must be notified at | þ                | Never Married 2 Married 3 Widowed 4 Divorced  | 1 □ Yes 2 No<br>If Yes, Give<br>Year or Dates:                                       | 1 🗆 Yes  | 2 Specify:  |   | Specify: B                       | lack   |
| 15-(              | n 72 h<br>I "natu<br>le zise  | olete            | 15. Decedent's Ed<br>(Specify only highest gra  | de completed)  | 16a. Decedent's Us<br>(Give kind of w<br>jite., DO NOT | ual Occupation<br>rork done during most of wo<br>use retired) |   | . Kind of Business/li            | ndustry  |
| 2121              | d within<br>giene.<br>er then "   | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5+)   | Da   | restic  | <u> </u>                                  | rivat                            | <u>و</u>   |
| Maryland          | ould be filed<br>  Mental Hygi<br>  Marked other<br>  hatic event,  | To Be (          | 17. Father's Name (First, Middle, Last) JOSEPH ROL  | inson  |  | 18. Mother's Na   | ime (First, Middle, Maid                  | ien Sumame)<br>hNSON             | 9  |
| Aary              | 2 should and Miles mail   |                  | 19a. Informants Name/Relationship (   | Type, Printy   | 19b. Mailing Addres                                    | ss (Street and Number or F                                    | Tural Route Number, Ci                    | ity or Town, State, Zi           | ip Code)   |
|                   | of Health<br>Item 27  |                  | 20a. Method of Disposition  | 296. Pl  | ace of Disposition (N                                  | ame of  | 2/20/05 200                               | : Location - City or T           | own, State   |
| altimore,         | Pages<br>nent of<br>int: If It<br>iry or o  |                  | ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  | Removal from State   | metery, crematory or                                   | Veterans Cer  | reten C                                   | TOWNSU I                         | 1/e MD   |
| Balti             | permit. Pages<br>Department of<br>Important: If II<br>any injury or o   |                  | 21. Signature of Funeral Service Licer  | Sico   | Value<br>Land  | and Address of Fality   | re ting                                   | al Sen                           | sices<br>1219                                      |
|                   |   |                  | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | one cause on each line.  |  |   | ac or respiratory arrest,                 |                                  | Approximate<br>Interval Between<br>Onset and Death |
|                   | Pnysician<br>/Medical   |                  | Immediate Cause (Final disease or condition resulting in death)   | . CHRONIC  |  | ex orea   | RE  |                                  | YS   |
|                   | Examiner  |                  |   | Due to (or as a consequence of the HYPCOZ  | ENSIVE   | VASCULA-  | R DISE                                    | AJE                              | YS   |
|                   | pe sit  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequ  | ence of):  |   |   |                                  |  |
| Ć.                | cate be executed<br>physician and<br>s the burial-transit   | Examiner         | that initiated events<br>resulting in death) Last   | c. Due to (or as a consequ   | ence of):  |   |   |                                  |  |
| 8760,             | ate be<br>hysicia<br>ihe bur  | dical            | (   | d  |  |   |   |                                  |  |
| 9                 | certific<br>iding p   | /Mec             | IF FEMALE:  | 23c. If yes, outcome of pregnar  | ncy  |   |   | 23d. Date of deliv               | /Arv   |
| P.O. Box          | requires that the death certifii<br>een signed by the ettending t<br>hould be detached for use as   | Physician/Me     | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  | 1 ☐ Live birth 2 ☐ Fetal<br>4 ☐ Pregnant at time of de<br>9 ☐ Unknown                |  |   | · · · · · · · · · · · · · · · · · · ·     | Month                            | Day Year   |
|                   | res that I<br>igned by<br>be deta   |                  | Part II. Other significant conditions of  |  |  |   | 23e. Did tobacc                           | co use contribute to             | the cause of death?                                |
| ord               | w require<br>been sig<br>should b   | ted t            | MENTAL RET  | ARDATION C   | HROMC  | HIVEMIA   |   | 2□No 3□Pro                       | bably 4 Unknown                                    |
| Records,          | ysician: The law<br>is carificate has b<br>director, page 2 sl  | Completed by     |   |  |  |   | 24a. Was an autopsy performed 1 Yes 2     | prior to co                      | opsy findings available ompletion of cause of      |
| Vita              | Physician: this cartificant   | Be               | 25. Was case referred to medical examiner?  | Hospital:  |  | Other   | eath (Check only one)                     |                                  |  |
| o                 | Phys<br>er this<br>eral dir   | ا:<br>ح          | 1 ☐ Yes 2 ☑ No  27. Manner of Death   | 28a. Date of Injury  | ER/Outpatient 3□ D<br>28b. Time of                     | 28c. Injury at  | Home 5 Residence 28d. Describe how in     |                                  | ify)   |
| sion              | ending<br>sath.<br>or: Afte<br>he fun   | atlo             | Natural 5 Pending 2 Accident investigation  | 1  | Injury<br>M  | Work?<br>1 ☐ Yes 2 ☐ No                                       |   |                                  |  |
| Division of Vital | al or Att<br>s efter de<br>al Direct  | Certification:   | 3 Suicide 6 Could not b 4 Homicide determined   | 28e. Place of Injury - At hor<br>building, etc. (Specify,                            | me, farm, street, facto<br>)                           | ry, office  | 28f. Location (Street<br>City or Town, St | t and Number or Rur<br>tate)     | al Route Number,                                   |
|                   | To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completaly filled in by the funeral  | Medical (        |   | ysicien: To the best of my knowniner: On the basis of examination and manner stated. |  |   |   |                                  |  |
|                   | To the<br>Within<br>To the<br>compl   | Me               | 29b. Signature and title of certifier   | - A  | 2  | 9c. License number  | 29d.                                      | Date signed (Month,              | Dey, Year)   |
|                   | Λ   |                  | * KKanga  | rape 141   |  | 1154288   |   | Remit                            | 10,000   |
|                   | 5   |                  | 30. Name and address of person who  | completed cause of death (Item   | 23a) (Type, Print)                                     | 9c. License number D54288 VORTHWEST /                         | MEDICAL                                   | CENTER                           |  |
|                   | Sta<br>Registr  |                  | 31. Date filed (Month Pan Ygar) 9   | 32. Segistrar's Signat   | K Coaste   | 7   |   |                                  |  |

|                     |  |                | For<br>State<br>Registrar   | State of I   | Maryland                                      | -                                    | artment of<br>tificate o  |                |                |   | iene<br>eg. No. 0 0              | 5                                   | 42119                                      |
|---------------------|--|----------------|---|--|---|--------------------------------------|---|----------------|----------------|---|----------------------------------|-------------------------------------|--|
| e i                 | Physici  |                | Decedent's Name (First, Middle, I   | ast)<br>Paula H  | elen Ro                                       | we                                   |   |                |                | 2. Date of Dea<br>Month<br>Decembe  | Day Y                            | ear<br>05                           | 3. Time of Death 4:18 A. M                 |
|                     | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, g  |  |   |                                      | 4b. City, Tow   |                | of Death       |   | 4c. County of Baltin             |                                     |  |
|                     | Funeral<br>Director  |                | Gilchrist Hosp: 5. Social Security Number 212 34 9470   |  | Age (In yrs. las                              | st birthday)<br>Yrs.                 | Tows of the state | ar If Unde     | Min.           | B. Date of Birth<br>(Month, Day<br>Oct. 28  |                                  | . Birthpl<br>Count                  | ace (State or Foreign<br>ry)<br>Land       |
| 100                 | ס  | or             | Usual Residence of Decedent  10a. State 10b. County   |  |   | Town or Lo                           |   |                |                |   |                                  | 10                                  | d. Inside City Limits                      |
|                     | h with the N<br>23a or 28a-1   | ai Director    | Maryland Cecil  10e. Street and Number  100 Greenway  | Apt. 101   |   | CII y v                              | 10f. Zip Cod  | 21903          |                | 1   | Og. Citizen of Wh                | at Count                            | ry?  |
| 920                 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If I tem 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, fra Mexical Esticiant Legistral and the multified at | by Funeral     | 11. Marital Status  1 Never Married 2 A Marned 3 Widowed 4 Divorced   | 12. Was Decede<br>Armed Force<br>1 Yes 2<br>If Yes, Give<br>Year or Date | es?<br><b>K</b> ∏No                           | 1                                    | Was Decedent<br>f Yes, specify 0<br>1 ☐ Yes 2√2   | uban, Mexica   | an, Puerto Hi  | ify Yes or No-<br>ican, etc.)   | 14. Race -<br>Black,<br>Specify: | White, e                            | tc.  |
| Maryland 21215-0036 | within 72 ho<br>ene.<br>than "natur<br>re Moulcal  | Completed      | 15. Decedent's (Specify only highest of Elementary/Secondary (0-12)   | Education<br>grade completed)<br>College (1-4                            |   | (Give                                | dent's Usual Oc<br>kind of work do<br>DO NOT use re<br>ier  | ne durina mo   | ost of working |   | 16b. Kind of Busin<br>Grocery    |                                     | •  |
| land 2              | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other than<br>aumatic event, the Mi   | To Be Co       | 17. Father's Name (First, Middle, La  | les Selte  | rs  |                                      |   |                |                | First, Middle, Bryant   | Maiden Sumame)                   |                                     |  |
|                     | 1 and 2 should<br>Health and Men<br>Iem 27 is marke<br>other traumatic   |                | 19a. Informant's Name/Relationship<br>Morris Rowe / H   |  |   | 100                                  | Greenwa   | y Apt.         | 100            | Perry   |                                  | aryl                                | and 21903                                  |
| Baltimore,          | Pe nen   |                | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe   | cify)  | ate cen                                       | netery, crer<br>ar Hi                | sition (Name on natory or other)  | ery            | 12/27/         | 2005  | 20c. Location - Ci               | e, M                                | aryland                                    |
| Ball                | permit. Departr Importe any inj  |                | 21. Signature of Funeral Service Lice   | ronue  | secured the death                             | 1 4                                  | 2. Name and Ad<br>OO1 Rit   | chie H         | ighway         | Balt  |                                  |                                     | , P.A.<br>and 21225                        |
|                     | Physician<br>/Medical<br>Examiner  |                | 23a. Sent 1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. | a. Due to (or  | S-Ma()  | ence of):                            |   |                |                |   |                                  |                                     | Interval Between<br>Onset and Death        |
| 8760,               | icate be executed<br>physicien and<br>s the burial-transit   | dicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last            | с  | as a conseque                                 |                                      |   |                |                |   |                                  |                                     |  |
| P.O. Box 6          | The law requires that the death certific<br>sie hes been signed by the attending p<br>page 2 should be detached for use as   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown  |  | h 2 ☐ Fetal d<br>nt at time of dea            | leath 3                              | Ectopic pregna<br>Other (specify  |                |                |   | 23d. Date<br>Month               |                                     | y<br>Day Year                              |
|                     | w requires that<br>been signed b<br>should be deta   | þ              | Part II. Other significant condition  | s contributing to dea  | th but not result                             | ting in the u                        | nderlying cause   | given in Pari  | t I.           | V   | bacco use contrib<br>es 2□No 3   | ute to th                           |  |
| Il Records,         | The law receive hes being page 2 sho   | Completed      |   |  |   |                                      |   |                |                | 24a. Was a autops perfor 1 Yes  | med? dea                         | re autop<br>or to con<br>th?<br>Yes | sy findings available apletion of cause of |
| ion of Vital        | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete his completely filled in by the funeral director, page  | ation: To Be   | 25. Was case referred to medical examiner?  1  Yes 2  Wo  27. Manner of Death  1  Salatural 5  Pending investiga  |  |   | P/Outpatier<br>28b. Time o<br>Injury | f 28c.  | Other          | Nursing Hom    | (Check only or<br>e 5  Residence of Residence o | ٢.                               | (Specify                            | hospice                                    |
| Division            | To the Hospital or Attend within 24 hours after death to the Funeral Director: completely filled in by the   | Certification: | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | ed 286. Place o  | f Injury - At hom<br>g, etc. <i>(Specify)</i> |                                      |   |                |                | City or Tow   |                                  |                                     |  |
|                     | To the Hospital<br>within 24 hours of<br>To the Funeral<br>completely filled   | Medical        |   | Physician: To the basaminer: On the basand manne                         | is of examination                             |                                      | vestigation, in r   | ny opinion, de | eath occurred  | d at the time, o  | late and place, an               | d due to                            | the cause(s)                               |
|                     | 7. ₹ £ 8   |                | Mena  | no completed cause   | of death (Item 1                              | 23a) (Tyne                           | D   | 5830           | 3              | î   | Decembe                          | - 24                                | f 200                                      |
| ,                   | 2 Sta  | ate            | 31. Date filed (Month, Day, Year)   | arlis mo   | gistrar's Signatu                             | N,                                   | Char  | es st          | Low            | on M  | 1) LIZO                          | £                                   |  |
| -3.5                | Regist   |                | DFC 2 9 2   | 005  | in M  | The s                                |   |                |                |   |                                  |                                     |  |

|             |  |                | For<br>State<br>Registrar   | State of Marylar  |                        | artment of rtificate of               |                            |                                    | iene 05                           | 12120   |
|-------------|--|----------------|---|---|------------------------|---------------------------------------|----------------------------|------------------------------------|-----------------------------------|---|
| 集           | W 8  | î .            | negistrar     Decedent's Name (First, Middle, Last)                           |   |                        | imodio or                             | Douth                      | 2. Date of Deat                    | h                                 | 3. Time of Death                                    |
| E           | Physicia<br>/Medic   |                | Margare   | t Elizabet  | h-Casl                 | key Sta                               | ck                         | December                           | Day Year 26, 2005                 | 4:15 PM   |
| 1           | Examin   | _              | 4a. Facility Name (If not institution, give s                                 |   |                        |                                       | or Location of Death       | -                                  | 4c. County of Dear                | h   |
|             |  | . 25           | 8489 New Cut Ro   |   | to a birds to b        |                                       | evern                      | 10.5                               | Anne Arı                          |   |
| 1           | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1  | 7. Age (In yrs.   | V                      | If Under 1 Year<br>Months Days        |                            | 8. Date of Birth<br>(Month, Day,   |                                   | hplace (State or Foreign<br>buntry)                 |
| ŀ,          |  |                | Usual Residence of Decedent   | 8   | 0                      |                                       |                            | SEP 28,                            | 1919   Sou                        | th Carolina   |
|             | how<br>Lat   | _              | 10a. State 10b. County  | 10c. Ci   | ty, Town or Lo         | cation                                |                            |                                    |                                   | 10d. Inside City Limits                             |
|             | 8a-f a   | Directo        | Maryland   Anne Aru   | ndel  |                        | Seve                                  | ern                        |                                    |                                   | 1 ☐ Yes 2 XNo                                       |
|             | B Or 2   |                | 10e. Street and Number  |   |                        | 10f. Zip Code                         | , ,                        | 11                                 | Og. Citizen of What Co            | ountry?   |
|             | nours arer dearn with the maryland<br>turel', or tems 23a or 28a-f ehow<br>al Exacilinatics truffiled at | Funerai        | 8489 New Cut Road   | 2. Was Decedent Ever in U                               | J.S. 13.1              | 211 Was Decedent of                   | 44<br>Hispanic Origin? (Sp | ecify Yes or No-                   | USA<br>14. Race - Ame             | rican Indian.                                       |
| 0           | or Items   | Fun            | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 XNo                             |                        | f Yes, specify Cu                     | ban, Mexican, Puerto       | Rican, etc.)                       | Black, Whit                       |   |
| 50          | nours and<br>sturel', or it  | d by           | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:                          |                        | 1 ☐ Yes 2 🏋 No                        | Specify:                   |                                    | Specify: V                        | Mhite   |
| 5-0036      | "natur   | Completed      | 15. Decedent's Educ<br>(Specify only highest grade                            |   | (Give                  | dent's Usual Occu                     | during most of work        | ang                                | 16b. Kind of Business             | Industry  |
| 2           | within 72<br>ene.<br>then "na!   | mp             | Elementary/Secondary (0-12)   | College (1-4or 5+)                                      |                        | DO NOT use retir                      | 90)                        |                                    | II 1 + 1                          |   |
| N :         | Hygid<br>Hygid<br>Sther<br>ant, I  |                | 17. Father's Name (First, Middle, Last)                                       | 4   | Nur                    | se                                    | 18. Mother's Nam           | e (First, Middle, N                | Healthc                           | are   |
| land        | Hental<br>Hental<br>Ked c  | To Be          | John L. Caskey  |   |                        |                                       | I Agg                      | ie Helms                           |                                   |   |
| Mary        | and N<br>e mar   | -              | 19a. Informant's Name/Relationship (Type                                      | oe, Print)  | 19b. Mailir            | ng Address (Stree                     |                            |                                    | City or Town, State,              | Zip Code)   |
| _           | and salth in 27 I  |                | James L. Stack/Gra  |   |                        |                                       |                            |                                    | MD 21032                          |   |
| Baltimore,  | t of Heall<br>If Item 2<br>or other  |                | 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re                    | emoval from State                                       | cemetery, crer         | sition (Name of<br>natory or other pl | ace)                       |                                    | 20c. Location - City or           | Town, State   |
| E '         | ury ury  |                | 4 □ Donation 5 □ Other (Specify)  | Met   | cro Cre                | matory,                               | Inc. 12/2                  | 28/05                              | Baltimo                           | ce, MD  |
| g<br>R      | Departi<br>Departi<br>Importi<br>eny inj   |                | 21. Signature of Funeral Service License                                      | M   | 22                     | Name and Addi<br>299 Fr               | ess of Facility (Y         | emation<br>ad Ralti                | Society of more, MD 2             | MD, Inc.  |
|             | 2,30   |                | Edward A Grego  23a. Part1. Enter the disease, or complice                    | orchik<br>cations that caused the dea                   | th. Do not ent         |                                       |                            |                                    |                                   | Approximate   |
| ١,          | t i . i  |                | shock, or heart failure. List only on<br>Immediate Cause (Final               | e cause on each line.                                   |                        | 0                                     | 1                          | ,                                  |                                   | Interval Between<br>Onset and Death                 |
|             | hysician<br>/Medical   |                | disease or condition resulting in death)                                      | Due to (or as a consec                                  | quence of):            | crest                                 |                            |                                    |                                   |   |
| Ê           | xaminer  |                | Consectable list and divine   | alzher  | mes                    | Des                                   | ease                       |                                    |                                   |   |
| ~           | 2 #5   | iner           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or a a consec                                   | quence of):            | 4                                     | - 01                       | 7                                  | 0 .                               |   |
|             | and<br>I-trans   | Examiner       | that initiated events c. resulting in death) Last                             | Due to (or as a consec                                  | uence of):             | - Luch                                | we Tul                     | mercary                            | Desause                           |   |
| 8/60,       | certificate by execution ding physicien and ise as the burial-transit                                    | dicai E        |   | Cardea  | c D                    | everhe                                | Almea                      | )                                  | Designs                           |   |
| 80          | g phys   |                | 0   |   |                        |                                       | 7777                       |                                    |                                   |   |
| X<br>O<br>D | attending p  | Physician/Me   | 230. Was decedent pregnant  | 3c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Feta |                        | Ectopic pregnan                       | cv                         |                                    | 23d. Date of del                  | •   |
| . 4         | he atten   | sicia          | in the past 12 months? 1 Yes 2 No   | 4 Pregnant at time of o                                 |                        | Other (specify)                       |                            |                                    | Month                             | Day Year  |
| л<br>С      | ned by the a   | Phy            | 9 ☐ Unknown  Part II. Other significant conditions con                        | tributing to death but not re-                          | auting in the cu       | adarhina sawas a                      | una ia Dart I              | 22a Did tab                        | acco use contribute to            | the saves of death?                                 |
| Š.          | equires that<br>een signed b<br>nould be deta  | by             | c 11 -  | ensém   | suiting at alle u      | idenying cadse g                      | iveri iri Fatti.           |                                    |                                   | obably 4 Unknown                                    |
| ecord       | w requires<br>been signe<br>should be  | etec           | Secret Hygiet   | 2000  |                        |                                       |                            |                                    |                                   |   |
| ě           | has<br>Je 2  | Completed      |   |   |                        |                                       |                            | 24a. Was an autops:                | y prior to death?                 | itopsy findings available<br>completion of cause of |
|             | certificate  | CO             | 25. Was case referred to medical  |   |                        |                                       | 26 Place of Deal           | 1 ☐ Yes 2                          | No 1 ☐ Yes                        | 2 No  |
| <b>&gt;</b> | S S  | OB             | examiner?<br>1 ☐ Yes 2 ☑ No   | ospital:  | ER/Outpatier           | t 3 DOA 0                             | thor                       |                                    | nce 6 ☐Other (Spe                 | city)   |
|             |  | Ju: T          | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending                                  | 28a. Date of Injury<br>(Month, Day Year)                | 28b. Time of           | 28c. Inj                              |                            | 28d. Describe ho                   |                                   |   |
| S IO        |  | catic          | 2 Accident investigation  |   |                        | M 1 [                                 | ]Yes 2 □No                 |                                    |                                   |   |
| DIVISION    |  | Certification: | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At h<br>building, etc. (Speci    | iome, farm, str<br>fy) | eet, factory, office                  |                            | 28f. Location (Str<br>City or Town | reet and Number or Ro<br>, State) | ıral Route Number,                                  |
|             | a nospital or<br>24 hours afte<br>Funeral Dire<br>letely filled in t                                     |                | 29a. Certifier 1 Certifying Phys  | ician: To the hest of my kn                             | nwledd deatl           | Secured at the                        | im : Pata and Alans        | and due to the en                  | us als) a vt mannar as            | stat s4   |
|             | E Fur  | edicai         | (Check only 2 Medical Examin<br>one)  | er: On the basis of examination and manner stated.      | ation and/or in        | vestigation, in my                    | opinion, death occur       | red at the time, da                | ate and place, and due            | to the cause(s)                                     |
|             | within 2<br>To the Complet   | ¥.             | 29b. Signature and title of certifier   | D. V.   |                        | 1                                     | ise number                 | 29                                 | 9d. Date signed (Mont.            | h, Day, Year)                                       |
| 1           | Ĺ  |                | 1 / axey D 5  | CTXING 1  | N.D.                   | 0                                     | 40904                      | D                                  | ecember                           | 27, 2005  |
|             | 1/1  |                | 30. Name and address person who con   | 2.4   | m 23a) (Type,          |                                       |                            |                                    | olis, MO                          |   |
|             |  |                | 31. Date filed (Month, Day, Year)   | _ KiNG; ML<br>32. Registrar's Sign                      |                        | 11/10                                 | rda Lane                   | Honay                              | olis, MU)                         | 4403  |
| 357         | Sta  | te<br>ar       | DEC 2 9 20  | Ja. Degistrar s olgn                                    | anui o                 | 9                                     |                            |                                    |                                   |   |

State Registrar

31. Date filed (Month, Day, Year) Registrar's Signature 9 2005

111 Penn Street, Baltimore, Maryland 21201

| Physician Medical Examiner  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  St. Agnes Hospital  St. Agnes Hospital  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  105 M 2 F  7. Age (in yis. last birthday)  Months  10a. Street and Number  10a. Strate  10b. Street and Number  10c. City, Town or Location  10d. Inside  10d. Street and Number  10d. | City Limits as 2 No                               |
|--|---|
| Physician Medical Examiner  4a. Facility Name (If not institution, give street and number)  4a. Facility Name (If not institution, give street and number)  5t. Agnes Hospital  S. Social Security Number  5t. Agnes Hospital  S. Social Security Number  6. Sex  1242-73. 3138  125M 2 7. Age (In yrs. last birthday)  10c. City, Town, or Location of Death  N/A  10d. Tyrs. Institution  10d. Inside  10 | P M or Foreign D City Limits as 2 \( \text{No} \) |
| As   Facility Name (if not institution, gives street and number)   As   Facility Name (if not institution, gives street and number)   As   Facility Name (if not institution, gives street and number)   As   Facility Name (if not institution, gives street and number)   As   Facility Name (if not institution, gives street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number)   As   Facility Name (if not institution, give street and number (if not institution, give street and number (if not institution, give street and number (if not institution, give street and number (if not institution, give street and number (if not institution, give street and number (if not institution, give street and number (if not institution, give street and number (if not institution, give street and number (if not institution, give street and num   | or Foreign  D  City Limits  s 2 \( \text{No} \)   |
| St. Agnes Hospital  St. Ag | City Limits as 2 No                               |
| Director  Direct | City Limits as 2 No                               |
| The part of the pa | etty  |
| To be the splane (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Informant's Name Relationship (Type, Print)  19. Informant's Name Relationship (Type, Print)  19. Mailing Address (Street and Number, Pural Route Number, City or Town, State, Zip Code)  20. Method of Disposition  20. Method of Disposition  20. Method of Disposition  20. Location - City or Town, State, Zip Code)   | ity<br>216  |
| To be the splane (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Informant's Name Relationship (Type, Print)  19. Informant's Name Relationship (Type, Print)  19. Mailing Address (Street and Number, Pural Route Number, City or Town, State, Zip Code)  20. Method of Disposition  20. Method of Disposition  20. Method of Disposition  20. Location - City or Town, State, Zip Code)   | ity<br>216  |
| To be the splane (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Informant's Name Relationship (Type, Print)  19. Informant's Name Relationship (Type, Print)  19. Mailing Address (Street and Number, Pural Route Number, City or Town, State, Zip Code)  20. Method of Disposition  20. Method of Disposition  20. Method of Disposition  20. Location - City or Town, State, Zip Code)   | ity<br>216  |
| To be the splane (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  19. Informant's Name Relationship (Type, Print)  19. Informant's Name Relationship (Type, Print)  19. Mailing Address (Street and Number, Pural Route Number, City or Town, State, Zip Code)  20. Method of Disposition  20. Method of Disposition  20. Location - City or Town, State   | 216   |
| policy of the state of Disposition (Name of Disposition - City or Town, State, Zip Code)  19a. Informant's Name Helationship (Type, Print)  19b. Mailing Address (Street and Number of Hural Route Number, City or Town, State, Zip Code)  2825 Cliffor Avenue Paltimore D 21  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)  | 216   |
| Consisting the second of Disposition (Name of Date 20c. Location - City or Town, State   | 216<br>MD   |
| Date 20c. Location - City or Town, State   | MD  |
|  | MD  |
| E de le la de la conation 5 Other (Specify) King Memorial Park DI. 03.06 Kangaustwn  |   |
| 114-12 S. Stricker Street Bullimore MD 2122  | 3   |
| 23a. Part1. Enter the it sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on lead hine.    Immediate Cause (Final   Narcotic And Alcohol Intoxication   Onset are consistent with the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval E Onset are consistent with the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval E Onset are consistent with the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval E Onset are consistent with the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval E Onset are consistent with the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval E Onset are consistent with the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval E Onset are consistent with the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death. Do not enter the district arrest arrest arrest  | etween  |
| /Medical disease or condition resulting in death)  Due to (or as a consequence of):  |   |
| Examiner  Sequentially list conditions, b.  The to (or as a consequence of).   |   |
| Cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   |   |
|  |   |
| W IF FEMALE:   |   |
| So the part of the | Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco use contribute to the cause of the ca |   |
| 1 Yes 2 No 3 Probably 4  | 3702  |
| 1   Yes 2   No 3   Probably 4    24a. Was an autopsy finding prior to completion of death?  24b. Were autopsy finding prior to completion of death?  25. Was case referred to medical examiner?  25. Was case referred to medical examiner?  26. Place of Death Check only one)  27. Manner of Death  1   Natural   S   Pending investigation    28a. Date of Injury   At home, farm, street, factory, office    28b. Time of   N   28c. Injury at work?  28c. Place of Death Check only one)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North, State)   19   S   Augustion    28d. Location (Street and Number or Rural Route North)    28d. Location (Street and Number or Rural Route North)    28d. Location (Street and Number or Rural Route North | cause of  |
| The state of the s |   |
| 1   Yes   2   No   No   1   Inpatient   2   ER/Outpatient   3   DOA   Outer   4   Nursing Home   5   Residence   6   Other (Specify)   |   |
| Comparison of the property o   | ımber.  |
| 27. Manner of Death   1  | sta Av  |
| 29a. Certifier (Check only one)  29b. Striature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year  | 3(s)  |
| 2 Accident 3 Suicide 4 Homicide City or Town, State) 12/25/05 4:32 P. M 1 Yes 2 No Unknown  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  HOUSE  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Six hature and title of certifier and manner stated.  29c. License number  29c. License number  29d. Date signed (Month, Day, Year December 26, 2005)  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WAND A KOREW 111 Penn Street, Baltimore, Maryland 21201  |   |
| State State Registrar  DFC 9 9 2005  |   |

| 11   |   | 1                         | For<br>State<br>Registrar  | State of                                     | of Marylan   |  | irtment of<br><i>tificate o</i>                   |                                      | nd Mental H                                | lygien<br>Reg. N                | 005   | 42123  |
|--|---|---------------------------|--|--|--|--|---|--------------------------------------|--|---------------------------------|---|--|
|  | ysicia  | n                         | Decedent's Name (First, Middle, La.     Andrew   | st)  |  | Sm                                     | allwood   |                                      | 2. Date of<br>Month<br>Decem               | Da                              | ay Year<br>21. 2005                                     | 3. Time of Death 5:50 P                            |
|  | Medica<br>camine  | r                         | 4a. Facility Name (If not institution, giv. 1030 Comet Street  | e street and nu                              | ımber)   |  | 4b. City, Town                                    | , or Location of E                   |  |                                 | c. County of Death                                      |  |
|  | eral<br>ector   |                           | 5. Social Security Number 6. S 215–70–3208   | ex<br>XM 2□F                                 | 7. Age (In yrs. 47   | last birthday)<br>Yrs.                 | If Under 1 Ye<br>Months Day                       |                                      | Min. (Month,                               | Birth<br>Day, Year<br>28–58     | r) Cou  | place (State or Foreign intry) Philda.             |
| deeth with the Maryland<br>ms 23a or 28a-f show  | other traumatic event, the Madical Examinar must be notified at | rai Director              | Usual Residence of Decedent  10a. State 10b. County  Md. NA  10e. Street and Number  2040 Orlean Str   |  | 10c. Cit   |  | imore   | 31                                   | 1? (Specity Yes or                         |                                 | itizen of What Cou<br>USA<br>14. Race - Amer            |  |
| 10 Z IZIO-0030  filled within 72 hours after d il Hygiene. other than "natural", or lien   | lical Examiner  | 2                         | 1 Never Married 2 Married  Muldowed 4 Divorced  15. Decedent's Ea  | Armed F<br>1 1 Yes<br>If Yes, G<br>Year or I | orces?<br>2 □ No<br>ive<br>Dates:  | 16a, Dece                              | f Yes, specify C □ Yes 2\nabla N lent's Usual Occ | uban, Mexican, F  lo Specify:        | Puerto Rican, etc.)                        |                                 | Black, White  | , etc.<br>lack                                     |
| ed within ygiene.  | the Mag   | Completed                 | Elementary/Secondary (0-12) 10th grade   | College (                                    | (1-4or 5+)   | life. L                                | Cook  | ne during most of<br>red)            |  |                                 | ood Staf  | £  |
| Taryland 2 should be file and Mental Hy is marked oth  | natic even  | - O Re                    | 17. Father's Name (First, Middle, Last, Johnnie  |  | Smal:  | lwood                                  |   | Ma                                   |  | W                               | ashingto  |  |
| MOFE, Mar<br>Pages 1 and 2 sh<br>nent of Health and<br>int: if item 27 is m  | or other traum  | -                         | 19a. Informant's Name/Relationship (  Mae Smallwood  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  | Mot  | 20b. F   | _ 1030                                 |   | Street,                              | Baltimo                                    | ce, M                           | Location - City or T                                    | 4<br>Town, State                                   |
| DESTRICTION permit. Pages Depertment of important: if its  | any injury<br>once.   |                           | 4 Donation S Other (Specification 21. Signature of Funeral Service Licer   | ·  | LI G   |  | nt Cem. Name and Add March E                      |                                      |  | imor                            | ltimore,<br>e, Md.<br>North Av                          | 21202  |
| Certificate be executed  We will be executed  We will be an executed  We will be an executed  We will be a continued by second and an executed  We will be a continued by second and an executed by seco | the burial-transit  | dical Exal                | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to                                    | caused the deat each line.  Or as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of as a consequence of a co | uence of):                             | ,   | disea                                |  | y arrest,                       |   | Approximate<br>Interval Between<br>Onset and Death |
| Geath<br>death<br>e atter  | d be detached for use as  | Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 1 Live                                       | atcome of pregna<br>birth 2 □ Feta<br>nant at time of d  | ıl death 3 □                           | Ectopic pregnal<br>Other (specify)                |                                      |  | _                               | 23d. Date of deliver Month                              | rery<br>Day Year                                   |
| HECOLDS, F.C. The law requires that the has been signed by the   | should be deta  | ted by PI                 | Part II. Other significant conditions of   | coho(  | death but not res  | sulting in the ur                      | nderlying cause                                   | given in Part I.                     |  | id tobacco<br>□ Yes 2           | _   | the cause of death?                                |
| I MeC<br>The law<br>ate has b  | ır, page 2 st   |                           |  |  |  |  |   |                                      | 1 1 Ye                                     | itopsy<br>erformed?<br>s 2 □ No | death?  | opsy findings available ompletion of cause of      |
| On Of<br>Jing Phys<br>I.<br>After this   | funeral di  | 0                         | 25. Was case referred to medical examiner?  1  Yes  No  27. Manner of Delith  1  Naturaf   | 28a. Date<br>(Mor                            | Inpatient 2  of Injury oth, Day Year)  | ER/Outpatien<br>28b. Time of<br>Injury | 28c. Ir   | 241                                  | 28d. Descri                                | esidence                        | 6 Sother (Speci   | <sup>(h)</sup> scene                               |
|  | led in by t   | Certification:            | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined   | buifd  | e of fniury - At h<br>ting, etc. <i>(Specit</i>  | <b>5</b> )                             |   |                                      | City or                                    | Town, Stat                      |   |  |
| To the Hospital within 24 hours a To the Funeral   | completely filled in  | Medical                   | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exar  29b. Signature and title of certifier   | niner: On the t                              | e best of my kno<br>pasis of examina<br>nner stated.   | owledge, death                         | estigation, in m                                  | time, date and p<br>y opinion, death | place, and due to t<br>occurred at the fin | ne, date an                     | s) and manner as and place, and due to a signed (Month, | o the cause(s)                                     |
| F 3 F  | 0   |                           | chame and address of person who  | Completed cau                                | a - Vol  | lalı p                                 | OCM   | E                                    |  | Dece                            | ember 22,   | , 2005   |
| 2  | State   | _                         | 31. Date filed (Month, Day, Year) DEC 9 200  | 32.1   | POLIAK<br>Registrar's Signa  | MD                                     | a decidence of the                                | n Street                             | t, Baltin                                  | ore,                            | Marylan   | 21201  |

|   |                 | 1- For State of Maryland / Department of He Registrar Certificate of D.  |                                |                                       | iene 05               | 42124  |
|---|-----------------|--|--------------------------------|---------------------------------------|-----------------------|--|
| Physici<br>/Medic   |                 | Decedent's Name (First, Middle, Last)  Evelyn Marie Scott  |                                | 2. Date of Deat<br>Month              |                       | 3. Time of Death   |
| Examin  |                 | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Le  UNIVERSITE SPECIALITE 1-65PITUL BACK  | MORE                           |                                       | 4c. County of         |  |
| Funeral<br>Director   |                 |  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Sep 13, | Year)                 | Birthplace (State or Foreign<br>Country)  Virginia                 |
| e Marylanda-1<br>Sa-1 show  | ctor            | 10a. State 10b. County 10c. City, Town or Location  Maryland N/A Balti   | imore                          |                                       |                       | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No                             |
| th with th<br>23a or 28   | ai Director     |  | 21229                          | 10                                    | 0g. Citizen of Wha    | it Country?  |
| ING 21215-0036  be filled within 72 hours after death with the Maryland hall Hygiene.  d other than "natural", or items 23s or 28s-f show event, the Medical Evanirer must be notified at | by Funeral      | 3 ☐ Widowed 4 ☑ Divorced   If Yes, Give X   1 ☐ Yes 2 ☐ No 3 ☐ X   |                                | ecify Yes or No-<br>Rican, etc.)      | 14. Race - /          | American Indian,<br>White, etc.                                    |
| - c - m   | Completed       | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired)  Homer   | ring most of worki             | ng                                    | 16b. Kind of Busin    |  |
| Maryland 212:<br>nd 2 should be filed within<br>the and Mental Hygiene.<br>27 is marked other than<br>traumatic event, the M  | To Be C         | 17. Father's Name (First, Middle, Last)  Hampston Green Jr.  | 8. Mother's Name               | Grad                                  | cie Green             |  |
| 39 - C - 5  |                 | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and  William Scott  20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  19b. Mailing Address (Street and  4547 The Strand  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Baltimore M                    | laryland 212                          |                       |  |
| Baltimore, I permit. Pages 1 and Department of Health Important: If item 21 on y injury or other 1 and 200.   |                 | '4 ☐ Donation     5 ☐ Other (Specify)       21. Signature of Funeral Service Licensee     Mt. Zion Cemetery       22. Name and Address of Service Licensee     22. Name and Address of Service Licensee  | of Facility                    | 2/29/05                               |                       | ne, Maryland   |
| Physician<br>/Medical   |                 | Estep Brott  23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each lige.  Immediate Cause (Final disease or condition resulting in death)  a. Cardiac avrythous resulting in death)  |                                | imore, Md 2<br>r respiratory arre     | 21217<br>st,          | Approximate Interval Between Onset and Death                       |
| Examiner  | ner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)  Lubertans I on   | - dise                         | as-e                                  |                       | 1 you  |
| 68760,<br>flicate be executed<br>physician and<br>is the burial-transit   | edicai Examiner | Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):   |                                |                                       |                       | 1045   |
| Box 6 death certif  | Physician/Medi  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknow |                                |                                       | 23d. Date of<br>Month | delivery<br>Day Year   |
|   | þ               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Diabeter mellitus. Nasophary gent mass  | n Part I.                      | 23e. Did toba                         |                       | e to the cause of death?  Probably 4 □Unknown                      |
| of Vital Records,  Physician: The law requires this certificate has been signeral director, page 2 should be e  | Completed       | Cremal neuropathy chronic menal ferlure Hypothymelism, Diohetic gastrupathy  | - 121 21                       | 24a. Was an autopsy performe          | 24b. Were prior death | autopsy findings available to completion of cause of ? es 2 1 No x |
| ding<br>Afte  | 10 B            | 1   Yes 22 No  | 2 No                           | e 5 Residen.                          | ce 6 Other (S         | pecify)<br>Rural Route Number,                                     |
|   | Medical Ce      | 29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination and/or investigation, in my opinio and manner stated.  | date and place, ar             | od due to the                         | - ( )                 | as stated.   |
| To the To the To the Comple   | Me              | 29b. Signature and title of certifier 29c. License nut   |                                | 290                                   | 1. Date signed (Mc    | onth, Dey, Year)   |
| State   |                 | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KDEAIMD USH 601 South charles Sh  31. Date filed (Manth, Day, Year)  |                                | Balhma                                | me mo                 | ब <i>१</i> २३ <i>०</i>   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 = State Ragistrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death M einer Zuth **Physician** 2005 27 4:00/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GARDEN BRIGHTONS COLUMBIA HOWARD If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 517.40.1138 1 ☐ M 2 € F Yrs. **Director** 86 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show ther must be notified at 1 ☐ Yes 2 No MDHOWARD COLUMBIA Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1110 MINSTREL WAY 21045 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 other than "natural", or 1 ☐ Yes 2 No Specify: þ Specify: BLACK 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YRS NURSE 12 TH GRADE HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental int: if item 27 is marked o JEFF MASSENBERG ESTHER JEFFERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MCELRATH SISTER) 6 172 GOOD HUNTERS RIDE COLUMBIA
Date COLUMBIA
20c. Location ALEASE MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department c important: if any injury or once. COLUMBIA PARK \* 4 □ Donation 5 □ Other (Specify) COLUMBIA, MD 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATU PIKE, BALTO. MO 21229 21. Signature of Funeral Service Licences ansim 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Alzhei Immediate Cause (Final disease or condition resulting in death) Dementa meris **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the attending physician by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? perten sion should be 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an was a.. autopsy performed? Yes 20 No has page 2 this certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 or Attending 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd, Columbia, 10780 HICKOM Ridar Harrn Li,

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

9 2005

32. Agistrar's Signature

|                     |  |               | 1 - For<br>State<br>Registrar   |           | State of                     | Maryla             | nd / Depa<br><i>Cei</i>   | artmen<br>rtificat                     | t of H<br>e of L       | lealth a                    | and M      | lental Hyg                                | iene) ()      | 5 1                    | 2126                            |
|---------------------|--|---------------|---|-----------|------------------------------|--------------------|---------------------------|--|------------------------|-----------------------------|------------|---|---------------|------------------------|---------------------------------|
| п                   | Physici  | an            | 1. Decedent's Name (First, Middl  | e, Last)  |                              |                    |                           |  |                        |                             |            | 2. Date of Deat<br>Month                  | h<br>Day      | Year                   | 3. Time of Death                |
|                     | /Medi  |               | Angelo  |           | rbello                       |                    |                           |  |                        |                             |            | D80                                       | 23            | 2005                   | 3 KM.W                          |
| 1                   | Examir   | ier           | 4a. Facility Name (If not institution   | n, give s | treet and numb               | oer)               |                           |  |                        | Location                    | of Death   |   | 4c. Coun      | ity of Death           |                                 |
|                     |  |               | Levindale  5. Social Security Number  | C Cav     | 7                            | A = 0 // 0 1100    | Land birdhaland           | If Under                               | Ltimo                  | ore<br>If Under             | 24 Hre     | 0.0-4                                     |               |                        |                                 |
|                     | Funeral<br>Director  |               | 212-76-0449   | 6. Sex    | M 2□F                        | . Age (in yr.      | s. last birthday)<br>Yrs. | Months                                 |                        | Hours                       | Min        | 8. Date of Birth<br>(Month, Day,          | Year)         | 9. Birthp              |                                 |
|                     |  |               | Usual Residence of Decedent   |           |                              | 02                 |                           |  |                        |                             |            | July 22,                                  | 1923          | J                      | MD                              |
|                     | yland<br>yland   |               | 10a. State 10b. County  |           |                              | 10c. C             | City, Town or Lo          | cation                                 |                        |                             |            |   |               | 1                      | Od. Inside City Limits          |
|                     | Mar<br>Me-f st   | ż             | MD Bali   | imo       | re                           |                    | Owing                     | s Mil                                  | lls                    |                             |            |   |               |                        | 1 ☐ Yes 21 No                   |
|                     | or 28  | Director      | 10e. Street and Number  |           |                              |                    |                           | 10f. Zip                               |                        |                             |            | 1   | 0g. Citizen o | f What Cour            | ntry?                           |
|                     | th wi  | al            | 200 Rosewood 1  | Lane      |                              |                    |                           |  | 2111                   | 17                          |            |   | USA           | A                      |                                 |
|                     | 72 hours after death with the Maryland<br>natural', or Itams 23a or 28e-f show<br>disal Examinar must be mutified at | Funeral       | 11. Marital Status  | 1         | 2. Was Decede<br>Armed Force | ent Ever in<br>es? | U.S. 13.                  | Was Deced                              | dent of Hi             | spanic Ori                  | gin? (Sp   | ecify Yes or No-<br>Rican, etc.)          |               | ace - Americ           |                                 |
| 36                  | or li  | by Fu         | 1 Never Married 2 Mar   |           | 1 ☐ Yes 2<br>If Yes, Give    | 41                 |                           | 1 ☐ Yes                                |                        | Specify:                    | ,          | ,   | Spec          |                        | Sto.                            |
| 21215-0036          | d within 72 hours after jiene.<br>r than "naturat", or l   | d b           | 3 Widowed 4 Divorced  |           | Year or Date                 | es:<br>            |                           |  |                        |                             |            |   |               | Wh                     | nite                            |
| 7                   |  | iete          | 15. Deceden<br>(Specify anly highe  |           |                              |                    | 16a. Deced                | dent's Usua<br>kind of wo<br>DO NOT us | al Occupa<br>rk done d | ation<br><i>during m</i> os | t of work  | in <b>g</b>                               | 16b. Kind of  | Business/In            | dustry                          |
| 12                  | filed within<br>Hygiene.<br>Ither than "   | Completed     | Elementary/Secondary (0-12) unknown   |           | College (1-4                 | or 5+)             | ,,,,,,                    |  | ablec                  |                             |            |   |               |                        |                                 |
| d 2                 | Hyg<br>the<br>int,   |               | 17. Father's Name (First, Middle,   | Last)     |                              |                    |                           | 2200                                   | .DICC                  |                             | er's Name  | e (First, Middle, M                       | Maiden Suma   | ame)                   |                                 |
| lan                 | d a b  | To Be         | Unknown   |           |                              |                    |                           |  |                        |                             | Unk        | nown                                      |               |                        |                                 |
| ary                 | 2 should<br>and Men<br>is marke<br>sumaric   | -             | 19a. Informant's Name/Relations   | hip (Typ  | oe, Print)                   |                    | 19b. Mailir               | ng Address                             | (Street a              | and Numbe                   |            | al Route Number,                          | City or Town  | n, State, Zip          | Code)                           |
| Σ                   | ges 1 and 2 should<br>tof Health and Mer<br>If itam 27 ia marke<br>or other traumatic                                |               | Department of A   | Agin      | g                            |                    |                           |  |                        |                             |            | on, MD 2                                  |               |                        |                                 |
| Baltimore, Maryland | of Heid<br>of Heid<br>fitam<br>rothe   |               | 20a. Method of Disposition  |           |                              | - 1                | Place of Dispo            | sition (Nar                            | ne of                  |                             |            |   | 20c. Location | - City or To           | own, State                      |
|                     | Pages<br>nent of I<br>int: If its<br>iry or o  |               | 1 ∰urial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S  |           | emoval from St               |                    | sewood                    | •                                      |                        | ´ 1                         | 2/24       | /05                                       | Owings        | . M:11                 | e MD                            |
| alti                | artm<br>artm<br>orts<br>inju   |               | 21. Signature of Funeral Service  | License   | θ ΛΛ.                        | 7                  |                           | . Name an                              |                        |                             |            |   | - Dati        |                        | n Road                          |
| m                   | Dep<br>Imp b   |               | Stephe  | n         | M.                           | Jen                | Kis E                     | line                                   | Fune                   | eral :                      | Ноше       | Reiste                                    |               |                        |                                 |
|                     |  |               | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complic   | cations that cau             | sed the dea        |                           | _                                      |                        |                             |            |   |               |                        | Approximate<br>Interval Between |
|                     | Physician  |               | Immediate Cause (Final disease or condition   | o, o      | C                            | cul                | - m                       | 476                                    | م جد                   | Liel                        | 00         | alace                                     | hin           |                        | Onset and Death                 |
|                     | /Medical   |               | resulting in death)   | a.        | Due to (or                   | as a conse         | equence of):              | 700                                    | 10                     |                             |            | 12  | 1.            |                        | 71000                           |
|                     | Examiner   |               | Secuentially list conditions  | b.        | G                            | ny                 | esti                      | re                                     | 4                      | ess                         | 1          | Ind                                       | lire          |                        | 76mont                          |
|                     | ס ≔  | iner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ,         | Due to (or                   | as a coe           | equence of):              |  |                        |                             |            | 1)  |               |                        |                                 |
| 6                   | ecute<br>and<br>-trans   | Examine       | that initiated events<br>resulting in death) Last   | c.        | D                            |                    |                           |  |                        |                             |            |   |               |                        |                                 |
| 8760,               | ate be executed<br>hysician and<br>the burial-transit  |               | and a death, and a  |           | Due to (or                   | as a conse         | quence or):               |  |                        |                             |            |   |               |                        |                                 |
| 87                  | 4 E E  | edical        |   | d.        |                              |                    |                           |  |                        |                             |            |   |               |                        |                                 |
| 9 ×                 | death certific<br>e attending p<br>id for use as t   | /Me           | IF FEMALE:  | 23        | Bc. If yes, outco            | me of pregr        | nancy                     |  |                        |                             |            |   |               | 1,                     |                                 |
| Вох                 | atten<br>for u   | Physician/M   | 23b. Was decedent pregnant in the past 12 months?   |           | 1 ☐ Live birt!               | h 2∏Fet            | tal death 3               | Ectopic pr<br>Other (sp                |                        |                             |            |   | 1             | ate of delive<br>lonth | ery<br>Day Year                 |
| Ö                   | 0 0  | ysic          | 1 □ Yes 2 □ No<br>9 □ Unknown   |           | 9 Unknow                     |                    | Oddii JL                  | J Other (sp                            | ocity)                 |                             |            |   |               |                        |                                 |
| ٦.                  | de de  |               | Part II. Dther significant condition  | ons conf  | tributing to deat            | th but not re      | sulting in the ur         | nderlying ca                           | ause give              | n in Part I.                |            | 23e. Did tob                              | acco use cor  | ntribute to th         | ne cause of death?              |
| Vital Records,      | uires<br>n sign  | d by          |   |           |                              |                    |                           |  |                        |                             |            | 1 ☐ Ye                                    | s 2 No        | 3 🗌 Prob               | ably 4 Unknown                  |
| 00                  | w requir<br>been si<br>should  | Completed     |   |           |                              |                    |                           |  |                        |                             |            | 24a. Was ar                               | 24h           | Were autor             | psy findings available          |
| Re                  | The law<br>ate has b<br>page 2 st  | m d           |   |           |                              |                    |                           |  |                        |                             |            | autopsy                                   | 1             | prior to cor<br>death? | npletion of cause of            |
| a                   |  | C             | 25. Was case referred to medica   |           |                              | /                  |                           |  |                        | 00 Dia-                     | -4 Da-14   |   | No            | 1 🗆 Yes                | 2□ No                           |
| <u>=</u>            | Physician:<br>this certific<br>ral director,   | o B           | examiner?   |           | ospital: 1 Inp               | ationt 25          | ☐ ER/Outpatien            | t 3 🗆 DO                               | Othe                   | 167                         | -          | n <i>(Check only one</i><br>me 5 ☐ Reside |               |                        |                                 |
| of                  |  | -             | 27. Manner of Death   |           | 28a. Date of                 | Injury             | 28b. Time of              |  | 8c. Injury<br>Work     |                             |            | 28d. Describe ho                          |               |                        | /)                              |
| on                  | 불구동호   | tlor          | 1 Natural 5 ☐ Pendir<br>2 ☐ Accident investi  |           | (Month,                      | Day Year)          | Injury                    | М                                      |                        | ?<br>∕es 2 ∐ l              | No         |   |               |                        |                                 |
| Division            | l or Attanding<br>after death.<br>Diractor: After<br>I in by the fune  | ertification; | 3 ☐ Suicide 6 ☐ Could   |           | 28e. Place of                | Injury - At I      | home, farm, stre          | eet, factory                           | , office               |                             |            | 28f. Location (Str                        | eet and Num   | ber or Rura            | l Route Number,                 |
| á                   | al or A  | Cert          | 4  Homicide   |           | building                     | , etc. (Spec       | city)                     |  |                        |                             |            | City or Town                              | State)        |                        |                                 |
|                     | To the Hospital or Al<br>within 24 hours after of<br>To tha Funaral Dirac<br>completely filled in by                 |               | 29a. Certifier 1 Certifyir  | g Physi   | ician: To the be             | est of my kn       | nowledge, death           | occurred                               | at the tim             | e, date an                  | d place, a | and due to the ca                         | use(s) and m  | anner as st            | ated.                           |
|                     | he He<br>in 24<br>ha Fu<br>pletel  | edical        | one)  | Examin    | and manner                   | r stated.          | ation and/or inv          | estigation,                            | in my op               | inion, dea                  | th occurr  | ed at the time, da                        | te and place  | , and due to           | the cause(s)                    |
|                     | To the within 2 To the complet   | Σ             | 29b. Signature and title of certifie  | r         | 0.1                          |                    |                           | 290                                    | . License              | number                      | ^          | 29  | d. Date sign  | ed (Month, L           | Dey, Year)                      |
| •                   | **   |               | ANDRA   | M         | , In                         | )                  |                           |  | 1)40                   | 981                         | +          | 7   | XEC           | 23                     | 2007                            |
|                     | 1  | - 11          | 30. Name and address of person.   | who car   | npleted cause                | of death (Ite      | m 23a) (Type,             | Print)                                 | 7                      | 1 1                         | 2 .        | aue                                       | .2            | alhin                  | 10 8                            |
|                     |  |               | Jan 111   | 27        | an                           | ~                  | 4774                      |  | 120                    | und                         | 40         | with                                      | 13            | 01/11                  | vare                            |
|                     | Sta<br>Registi   |               | 31. Date filed (Month, Day/Year)  | 2005      |                              | istrar's Sigr      | iature .                  | Was !                                  |                        |                             |            |   |               |                        |                                 |
|                     | 3,51   |               | nor man W   |           | 1 2 6 4 All                  |                    | a A                       |  |                        |                             |            |   |               |                        |                                 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Virginia Lee Smith Year Physician 9:47 P M December 20. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore at Gilchrist Towson
If Under 1 Year If Under 24 Hrs. Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2√XF 220-40-9690 64 Sept Director Ohio Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show the mast be notified at MD Baltimore Towson 1 ☐ Yes 2/XNo Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 504 West Chesapeake Avenue 21204 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 元 🛪 Specify: δ 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 7 is marked other than "natur traumatic event, Ins Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental Clarence Smith Marcia W. ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health an Important: If item 27 is any injury or other trau once. 21084 Becky Litwak 3816 Salem Church Road Jarrettsville MD of Disposition (Name of (Cousin) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12/22/05 Catonsville, MD 22. Name and Address of Facility
Rursec-Henss-Seitz Funeral
3031 Falls Koad Balto, MD 21. at e of Faneral Service Licensee 23a. Part1. Enter the disease, or complication that caused the death. Do not enter shock, or heart failure. List only one caus in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 1 ☐ Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No al Director: A ad in by the fr investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 | Homicide within 24 hours after To the Funeral Dire Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) 29b. Signature and title of certile

Registrar

10

State

30. Name and address of person

31. Date liled (Month, Day, Year)

DEC 2 9 2005

6201

N. Charles St. Bolto. MN 21208

who completed suse of death (IIIm 23a) (Type, Print)

. Registrar's Signature

SANC

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WILLIE SALESKY 145 AM 28 2005 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Under 24 Hrs. Jewish Convalescent Home Baltimore If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Funeral Davs Min. **Х**ДМ 2□ F Months Hours 114-12-1466 86 Yrs. New York Director April 19,1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deperment of Health and Mental Hygiene. Imprortant: if iten 27 is marked other than 'natural', or items 23a or 28a-1 show enty Injury or other tran-matic event, The Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 ☐ Yes 2 ☐ XTXO Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 Scotts Level Road 21208 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Y Yes 2 No If Yes, Give Year or Dates: WW 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: Specify: White ۾ II 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Attorney Private Practice 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sam Salesky Mollie Aschkenazy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pauline Jacobs (Daughter) 5733 Greenspring Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XXX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12/30Catonsville, MD 21. Signature of Funeral Service Licensee Burgee-Henss-Seitz Funeral Home, Inc. 363Ĭ Falls Road Balto, MD 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical End Stage Deme Examiner Due to (or as a consequence of): Physician/Medical Examine The law requires that the death certificate be executed been signed by the attending physician and should be deteched for use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to tha causa of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Onknown þ this certificete hes been signal director, page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? TLYUS ZENO 1 ☐ Yes 2 ☐ No or Attending Physician: efter death.

Director: After this certifice To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 11 Cartifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer). Elou AR Diati 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Dikesville cotts 31. Date filed (Month, Day, Year) egistrar's Signature State DEC 29 2005

DHMH 16 Rev 6/95

Registrar

|                     |  |               | For State   | State of Marylan                                    | d / Depa           |   | Health an  | d Mental Hy  | giene (           | 5 42129  |
|---------------------|--|---------------|---|---|--------------------|---|--|--|-------------------|--|
|                     |  |               | Registrar  1. Decedent's Name (First, Middle, Last)                                 |   |                    | inoate of   | Doain  | 2. Date of Dea   | Reg. No.<br>ath   | 3. Time of Death   |
|                     | Physici  | an            |   |   |                    |   |  | Month  | Day               | Year   |
|                     | /Medic   |               | Melissa O. Spicer  4a. Facility Name (If not institution, give st                   | reet and number                                     |                    | 4b. City, Town,   | or Location of D   | 12-22-   | 4c. County        | J:20 P   |
|                     | Examin   | er            | Genesis Elder Care  |   |                    | Severna   |  | odui   |                   |  |
|                     |  |               | 5. Social Security Number 6. Sex  | 7. Age (In yrs.                                     |                    | If Under 1 Year   |  | Hrs. 8. Date of Birt   |                   | Arundel  9. Birtholage (State or Foreign                                     |
|                     | Funeral Director   |               |   | M 2×1 91  | Yrs.               | Months Days   |  | 7-30-19  | y, Year)          | Birthplace (State or Foreign Country)     NC                                 |
|                     |  |               | Usual Residence of Decedent   | 71  |                    |   |  | 7-30-1   | 714               | 110  |
|                     | yland  |               | 10a. State 10b. County  | 10c. Cit  | y, Town or Lo      | ocation   |  |  |                   | 10d. Inside City Limits  |
|                     | Mar.   | tor           | MD Anne Arun  | nde1  | Glen B             | urnie   |  |  |                   | 1 ☐ Yes 2 ☑ No   |
|                     | n the  | Director      | 10e. Street and Number  |   |                    | 10f. Zip Code   |  |  | 10g. Citizen of \ | What Country?  |
|                     | death with the Maryland<br>ma 23a or 28e-f ehow<br>Linust be notified at   |               | 122 Shelly Road   |   |                    | 21061   |  |  | U.S.A.            |  |
|                     | dea  | Funeral       |   | Was Decedent Ever in U     Armed Forces?            | .S. 13.            | Was Decedent of   | Hispanic Origin  | ? (Specify Yes or No-<br>uerto Rican, etc.)  |                   | ce - American Indian,<br>ck, White, etc.                                     |
| ٥                   | after<br>or ite  |               | 1 ☐ Never Married 2 ☐ Married   | 1 ∐Yes 2X No  |                    | 1 ☐ Yes 2 No  |  | donto rnoun, oto.,   |                   | y: White   |
| 3                   | be filed within 72 hours after death with the Marylan<br>ital Hygiene.<br>In death than anatural, or itema 23a or 28e-f show<br>death, the Madical Examinal must be nutited at | d by          | 3℃ Widowed 4 □ Divorced   | Year or Dates:                                      |                    |   |  |  | Specify           | y  |
| አ<br>አ              | 72 h   | Completed     | 15. Decedent's Educi<br>(Specify only highest grade                                 | ation<br>completed)                                 | 16a. Dece<br>(Give | dent's Usual Occu<br>kind of work done<br>DO NOT use retire | pation<br>during most of   | working  | 16b. Kind of Bu   | usiness/Industry   |
| 7                   | within 72<br>ene.<br>than *nat   | E E           | Elementary/Secondary (0-12)   | College (1-4or 5+)                                  |                    |   |  |  | TT 4-2            | .1   |
| N                   | filed v<br>Hygie<br>other t  |               | 12 17. Father's Name (First, Middle, Last)  |   | Execu              | tive Sec  |  | Name (First, Middle,   |                   | nghouse  |
| ב                   | lid be findental Hicked of   | Be            | Theo Easom  |   |                    |   |  | tavia Anne   |                   | ,  |
| چ                   | should<br>and Men<br>s marks<br>umatic   | ٦<br>م        |   | - 0-1-11  | 405-14-25          |   |  |  |                   |  |
| Maryland 21215-0036 | 0 .0 = 6   |               | 19a. Informant's Name/Relationship (Typ   |   | 1                  |   |  | r Rural Route Numbe  |                   |  |
|                     | 1 and<br>Health<br>Bm 27<br>ther tr  |               | Mrs. Anne Brownson  20a. Method of Disposition                                      |   |                    |   |  | en Burnie,   |                   | JOI<br>- City or Town, State   |
| Baltimore,          | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any injury or other<br>once.   |               | ↑SBurial 2 Cremation 3 Re   | mioval from State                                   |                    | sition (Name of<br>matory or other pla                      | 1  |  |                   |  |
|                     | t. Pa<br>tmer<br>tant  |               | 4 Donation 5 Other (Specify)  |   |                    |   |  | 2-27-05  |                   | ırnie,MD   |
| a<br>a              | permit. Departr Importa any inji   |               | 21. Signature of Fundul Service License   | m13/  | T. II.             |   |  |  |                   | al Home, PA  |
|                     | 40 = e a   |               | 1 NN nu ville   | 1110100   |                    |   |  | Glen Burn  | <del></del>       |  |
|                     |  |               | 23a. Part1. Enter the disease, or complic<br>shock, or heart failure. List only one | e cause on each line.                               |                    |   |  |  | rest,             | Approximate<br>Interval Between<br>Onset and Death                           |
|                     | Physician  |               | Immediate Cause (Final disease or condition resulting in death)                     | F   | Sch                | mil   | Cocdio   | my of ally   |                   | 3M   |
|                     | /Medical<br>Examiner   |               | resulting in coatin)  | Due to (or as a conseq                              | uence of):         |   |  | 1  |                   |  |
|                     |  | _             | Sequentially list conditions, b.  | Due to (or as a conseq                              |                    |   |  |  |                   |  |
|                     | ed<br>sit  | Examiner      | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury       | Due to for as a conseq                              | dende ory.         |   |  |  |                   |  |
|                     | be executed<br>ician and<br>burial-transit   | xan           | that initiated events c. resulting in death) Last                                   | Due to (or as a conseq                              | uence of);         |   |  |  |                   |  |
| 160                 | icate be executed<br>physician and<br>s the burial-transit   | calE          |   |   | ,                  |   |  |  |                   |  |
| 289                 | leath certificate b<br>altending physic<br>I for use as the b  |               | d.  |   |                    |   |  |  |                   |  |
|                     | death certifica<br>e altending ph<br>id for use as th  | Physician/Med | IF FEMALE:<br>23b. Was decedent pregnant  | c. If yes, outcome of pregna                        | incy               |   |  |  | 23d Dat           | te of delivery   |
| ROX                 | alter<br>I for u   | ciar          | in the past 12 ponths?  | 1 Live birth 2 Feta<br>4 Pregnant at time of d      |                    | Ectopic pregnand Other (specify) _                          | у  |  | Mo                |  |
| o                   | the d<br>y the<br>ached  | ıysi          | 1 ☐ Yes 2 TNo<br>9 ☐ Unknown  | 9□ Unknown  |                    |   |  |  |                   |  |
| J.                  | The law requires that the de<br>ste has been signed by the a<br>page 2 should be detached  | y Pł          | Part II. Other significant conditions cont  | ributing to death but not res                       | ulting in the u    | nderlying cause g   | ven in Part I.   | 23e. Did to  | bacco use conti   | tribute to the cause of death?   |
| Kecords,            | puires   | d by          |   |   |                    |   |  | 1 🗆 Y  | es 2 500          | 3 Probably 4 Unknown   |
| <del></del> ဂ္ဂ     | w rec  | lete          |   |   |                    |   |  | 24a. Was   | an 24b. \         | Were autopsy findings available  |
| e<br>T              | he la<br>e has<br>age 2  | Completed     |   |   |                    |   |  | autop<br>perfor  | rmed?   c         | Were autopsy findings available<br>prior to completion of cause of<br>death? |
| Vital               | sician: The law<br>s certificate has b<br>irector, page 2 s  | Ç             | 25. Was case referred to medical  |   |                    |   | 26 Place of  | 1 ☐ Yes<br>Death (Check only or  |                   | 1 Yes 2 No   |
|                     | Physician:<br>rthis certific<br>ral director,  | 0             | evaminar?   | ospital:  | ER/Outpatier       | nt 3□ DOA Ot  | her  | ig Home 5 ☐ Resid  |                   | par (Spacity)  |
| Ö                   | ding Physician:<br>h.<br>After this certifica<br>funeral director,   | on: T         | 27. Manner of Death   | 28a. Date of Injury                                 | 28b. Time of       |   | and the second s | A Part and the Control of the Contro | ow injury occurr  |  |
| <u></u>             | nding:   | atlo          | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation                                 | (Month, Day Year)                                   | Injury             |   | ork?<br>]Yes 2∐No  |  |                   |  |
| DIVISION            | al or Attending<br>after death.<br>I Director: After<br>d in by the fune   | ific          | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury - At he building, etc. (Specif | ome, farm, str     | eet, factory, office  |  | 28f. Location (S<br>City or Tow  | Street and Numb   | per or Rural Route Number,   |
| ā                   | al or Att  | Certificat    | 4 I Hornicide   | building, etc. (Specif                              | "                  |   |  | City of 10w  | m, State)         |  |
|                     | bour<br>hour<br>unera<br>ly fille  | cai (         | 29a. Certifier 1 Certifying Physi (Check only 2 Medicel Examin                      | cian: To the best of my kno                         | wiedge, death      | n occurred at the t   | me, date and pl  | ace, and due to the  | cause(s) and ma   | anner as stated.   |
|                     | To the Hospital of within 24 hours at To the Funeral D completely filled in  | edical        | one)  | er: On the basis of examina<br>and manner stated.   | ariana/or in       |   |  |  |                   |  |
|                     | with<br>To 1   | Σ             | 29b. Signature and title of certifier   | ^   |                    |   | se number  |  | 29d. Date signed  | d (Month, Day, Year)   |
|                     |  |               | My lanu   | JUN S   |                    | 0   | 39036  | 0  | 12/2              | 317002   |
|                     | 1D   |               | 30. Name and address of pers who con  |   | 23а) (Туре,        | Print)  | Λ-   | C A 1  | 40                | 3/2005   |
|                     | 1-   |               | and the   | use 210.  | 7 ()1              | UChuh   |  | L Ches   | m. Mi             | 34/4/9   |
|                     | Sta<br>Registr   |               | 31. Date filed (Month, Day, Year)   | 32. Degistrar's Signa                               | ture               | works.  |  |  |                   |  |
|                     | negisti  | CIT .         | DEC 2 9 200'  | 1 55 SEC. 18 1                                      | U                  | -   |  |  |                   |  |

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|----------|--|------------------|--|--|--|---------------------------------------|---|--|--------------------------|---|---|
|          |  |                  | 1 _ State  | State of Maryland  |  |                                       |   | Mental Hy                              | giene                    | 05 [  | 12130   |
|          |  |                  | Registrar  1. Decedent's Name (First, Middle, Last)                                |  | Certiii                                | icate of l                            | Jeain                                   | 2. Date of De                          | Reg. No.                 |   | 7 Time of South                                 |
|          | Physicia<br>/Medic   | al               | HENRY A  4a. Facility Name (If not institution, give st.                           |  | hann                                   |                                       | Location of Death                       | Decen                                  | when I                   | Year<br>2005<br>County of Death                     | 3. Time of Death                                |
|          | Examin   | er               |  | re Hosbit  | al a                                   | Ro                                    | sedal4                                  |  | 40.                      | Baltin  | More  |
| . }      | Funeral<br>Director  |                  | 5. Social Security Number 6. Sex   |  |  | Under 1 Year<br>onths Days            | If Under 24 Hrs.<br>Hours Min.          | 8. Date of Bir<br>(Month, Da<br>Aug 07 | th<br>y, Year)<br>, 192  | 9. Birthp   | place (State or Foreign<br>offy)<br>yland       |
| ī        | and w  |                  | Usual Residence of Decedent  10a. State 10b. County                                | 10c. City.   | Town or Location                       | on                                    |   |  |                          | 1   | 0d. Inside City Limits                          |
|          | Maryli<br>f sho  | tor              | MD Baltimor  |  | Essex                                  |                                       |   |  |                          |   | 1 ☐ Yes 2 🔀 No                                  |
|          | th the   | Funeral Director | 10e. Street and Number   |  | 1                                      | Of. Zip Code                          |   |  | 10g. Citiz               | en of What Cour                                     | itry?   |
|          | ath wi   | ral              | 508 N. Stuart St   |  |  | 21221                                 |   |  | USA                      |   |   |
|          | ter de   | -une             | 11. Marital Status 12 Never Married 2 Married 12                                   | <ol> <li>Was Decedent Ever in U.S<br/>Armed Forces?</li> <li>1 Gryes 2 □ No</li> </ol> | i. 13. Was                             | Decedent of Hi<br>s, specify Cuba     | spanic Origin? (S<br>n, Mexican, Puert  | pecify Yes or No<br>o Rican, etc.)     | - 1                      | <ol> <li>Race - Americ<br/>Black, White,</li> </ol> |   |
| 22       | within 72 hours after death with the Maryland<br>ene.<br>Then "natural", or items 23a or 28a-1 show<br>ha Madical Examiner must be notitied at   | by               | 3 ☐ Widowed 4 ☐ Divorced   | 1 ☑ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:                                       | 10'                                    | Yes 2 No                              | Specify:                                |  |                          | Specify:Whi   | te  |
| ה<br>ה   | 72 ho  | Completed        | 15. Decedent's Educa<br>(Specify only highest grade                                | ation<br>completed)  | 16a. Decedent'                         | s Usual Occupa<br>of work done        | ation<br>furing most of wor<br>)        | king                                   | 16b. Kin                 | d of Business/Inc                                   | ustry   |
| 7        | within<br>ene.<br>then<br>the Me   | dwc              | Elementary/Secondary (0-12)  | College (1-4or 5+)   | Firema                                 |                                       | )                                       |  | Fir                      | eman  |   |
| 2        | e filed<br>Il Hygid<br>Other<br>Vent, I  | Be C             | 7th<br>17. Father's Name (First, Middle, Last)                                     |  |  |                                       | 18. Mother's Nan                        | ne (First, Middle,                     | Maiden S                 | Sumame)   |   |
| Na.      | should be<br>nd Mental<br>marked c   | To E             | Henry N. Tellj   | ohann Sr.  |  |                                       | Elizab                                  | eth Bu                                 | sse                      |   |   |
| Mar      | C1 40 10 10  |                  | 19a. Informant's Name/Relationship (Type<br>Mary Telljohann                        |  | -                                      |                                       | and Number or Rurt Stre                 |  | -                        | ·   | Code)   |
| ย์       | Health<br>tem 27<br>other tr   |                  | 20a. Method of Disposition   |  | ace of Disposition                     |                                       |   | Date                                   |                          | ation - City or To                                  | own, State                                      |
| Ē        | Pages<br>nent of<br>nnt: if i  |                  | 1 X Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)                | moval from State Sac   | credHea                                | rtofJ                                 | esus12/                                 | 31/05                                  | Bal                      | timore  | MD  |
| Dalillio | permit. Pages 1 and<br>Department of Heall<br>Importent: if Item 2<br>any injury or other<br>2005e.  |                  | 21. Signature of Funeral Service Licensee  | 0  | 22. Na                                 | ame and Addres                        | s of Facility Co                        | nnelly                                 | Fune                     | ralHome   | eofEssex  |
|          | 2 0  |                  | 23a. Part 1. Enter the disease, or complication                                    | ations that caused the death.  | bo not enter the                       |                                       | ace Ave                                 |  |                          | e MD 2  | Approximate                                     |
| ı        | Physician  |                  | shock, or heart failure. List one Immediate Cause (Final disease or condition      | Vierria.   | LAR Fi                                 | BRILL                                 | A TION I                                | OLTH A                                 | cet                      | M.1   | Interval Between<br>Onset and Death             |
| 100      | /Medical<br>Examiner   |                  | resulting in death)  | Due to (or as a conseque   | ence of):                              | -                                     | ,                                       | . 1                                    |                          |   |   |
| W.       | * \$2.   | Iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Que to (or as a conseque   | CVA                                    | +12                                   | ABRTR                                   | s Yeli                                 | des                      | . >   | 542   |
| Ď        | te be executed<br>ysician and<br>te burial-transit   | Examiner         | Cause (Disease or injury that initiated events c. resulting in death) Last         | Due to (or as a conseque   | ence of):                              |                                       |   |  |                          |   |   |
| 0000     | ate be<br>thysicianthe bu  | dical            | . € d.   |  |  |                                       |   |  |                          |   |   |
| ם אחם    | certific<br>nding p  | /Me              | IF FEMALE: 23b. Was decedent pregnant 23   | c. If yes, outcome of pregnan  | cy                                     |                                       |   |  | 2:                       | 3d. Date of delive                                  | nov   |
| 5        | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Biractor: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the | Physician/Medi   | in the past 12 months?  1  Yes 2 No  | 1□Live birth 2 □Fetal of 4□Pregnant at time of dea 9□Unknown                           |  | opic pregnancy<br>ner (specify)       |   |  |                          | Month   | Day Year  |
| Ļ        | s that t<br>ned by<br>e detar  | by Ph            | Part II. Other significant conditions conti  | ributing to death but not resul  | ting in the underl                     | lying cause give                      | en in Part I.                           | 23e. Did t                             | obacco us                | e contribute to th                                  | ne cause of death?                              |
| ecords,  | equire<br>en sig<br>ould b   |                  |  |  |  |                                       |   | 10                                     | Yes 2.⊠                  | No 3□Prob   | ably 4 Unknown                                  |
| 2        | alawr<br>hasbe<br>e 2sh  | Completed        |  |  |  |                                       |   | 24a. Was<br>autor                      | osy                      | prior to cor  | psy findings available<br>impletion of cause of |
| L.       | n: The<br>ficate<br>or, pag  |                  | OS Man and referred to medical   |  |  |                                       |   | 1 Tes                                  |                          | death?  | 2 No  |
| =        | reicia<br>s certi  | То Ве            | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No                          | ospital:<br>1 ☐ Inpatient 2 🔀 E  | R/Outpatient 3                         | Othe Othe                             | 26. Place of Dea                        |  |                          | Other (Specifi                                      |   |
| 5        | ling Phy   |                  | 27. Manner of Death 1 ⊠Natural 5 □ Pending   |  | 28b. Time of Injury                    | 28c. Injury<br>Work                   | at                                      | 28d. Describe I                        |                          |   | 7   |
| VISION   | Attend<br>death<br>ctor: ,<br>y the f  | flcat            | 2 Accident investigation 3 Suicide 6 Could not be determined                       | 28e. Place of Injury - At hon  |  |                                       | /es 2 □No                               | 28f. Location (                        | Street and               | Number or Rura                                      | l Route Number.                                 |
| 5        | ital or urs after rai Dire   | Certification:   | 4   Homicide   | building, etc. (Specify)   |  |                                       |   | City or To                             |                          |   |   |
|          | To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: The this certificate has completely filled in by the funeral director, page 2 to mpletely filled in by the funeral director, page 2 to make the funeral director.                        | edical           | 29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine              | cian: To the best of my know<br>er: On the basis of examination<br>and manner stated.  | ledge, death occ<br>on and/or investig | curred at the tim<br>gation, in my op | e, date and place<br>sinion, death occu | , and due to the<br>rred at the time,  | cause(s) a<br>date and p | and manner as st<br>place, and due to               | ated. the cause(s)                              |
|          | To th<br>within<br>To th<br>comp   | Me               | 29b. Signature and title of certifier  |  |  | 29c. License                          | number                                  |  |                          | signed (Month,                                      |   |
| -        |  |                  |  | Pul  |  | D14                                   | 22/                                     |  | 12                       | 2.28  | .05   |
| 0        | 1  |                  | 30. Name and address of person who com   | 0/ 22  | 3 E.B.                                 | LVO B                                 | ALT.                                    | MD 21                                  | 22                       | /   |   |
|          | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year) DEC 2 9 201                                      | 32. Registrar's Signatu  | 110                                    |                                       | <del>/</del>                            | <u> </u>                               |                          |   |   |
|          | negisti  | ᄪ                | DEC 6 3 7111   | 13 Marg 1  | The Borne                              | Sec. 3                                |   |  |                          |   |   |

| Consider Continued   Continu   |              |  |            | 1 = For<br>State<br>Registrar  | State of Ma  | -                    | epartment of I<br>Certificate of              |                               | ind Mental Hy                                      | giene                                   | 5 4                     | 2131  |
|--|--------------|--|------------|--|--|----------------------|---|-------------------------------|--|---|-------------------------|---|
| TOTAL PROPERTY OF THE PROPERTY | The Control  | The second of  |            | 1. Decedent's Name (First, Middle, L.                                | ast)   |                      |   |                               |  |   | Year                    | 3. Time of Death                              |
| Security Number   10   10   10   10   10   10   10   1   |              |  |            | KIMBERLY   |  |                      | THO   | MAS                           | DEEMBE   | R 27                                    | 2005                    | 05:30 A M                                     |
| Second Security Numbers   Security Numbers   Securi   |              |  |            |  | ve street and number)                              | /                    | 4b. City Town,                                | or Location o                 | f Death  | 4c. Coun                                | ty of Death             |   |
| The control of the c  |              |  |            |  |  | Spital               | Dali  |                               |  |   |                         |   |
| 100. Shad and Number   100. Conty   100. C   | *            |  |            | 215-74-9620  |  |                      | Months Days                                   |                               | Min. (Month, Da                                    | y, Year)                                | 9. Birth                |   |
| Security of Proposed voth supposed or and composed   Colored (1-for 5)   |              | and  |            |  |  | 10c. City, Town o    | r Location                                    |                               |  | *************************************** |                         | 10d. Inside City Limits                       |
| Security of Proposed voth supposed or and composed   Colored (1-for 5)   |              | Mary<br>f • hc   | ō          | MD   |  | BALT                 | IMORE   |                               |  |   |                         | 1X Yes 2 ☐ No                                 |
| Security of Proposed voth supposed or and composed   Colored (1-for 5)   |              | 28a  | Je C       | 10e. Street and Number   |  |                      | 10f. Zip Code                                 |                               |  | 10g. Citizen o                          | f What Cou              | ntry?   |
| Security of Proposed voth supposed or and composed   Colored (1-for 5)   |              | 3a or  | i          | 2640 E. BIDDLE   | STREET   |                      | 2121  | .3                            |  | US                                      | A                       |   |
| Security of Proposed voth supposed or and composed   Colored (1-for 5)   | 036          | ours after death   | þ          | 11. Marita! Status  1 Never Married 2 Married                        | 12. Was Decedent Ender Armed Forces?  1  Yes 2  No |                      |   |                               | gin? (Specify Yes or No<br>, Puerto Rican, etc.)   |   | lack, White,            | etc.  |
| 18. Momers after (First Model, Last)  LAMONT EPS  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or Russ Rosel, Number City or Town, State, Zip Code)  19. Maining Address (Sinest and Number or R | 215-0        | 27 8 3   | npietec    | (Specify only highest g  | rade completed)                                    | ((                   | Give kind of work done                        | during most                   | of working   | 16b. Kind of                            | Business/Ir             | ndustry                                       |
| The state of the s |              | ed wi  | 5          |  | 1  |                      | DATA PROCES                                   |                               |  |   |                         |   |
| AMONT EPPS  The attendance is in the control of the | nd           | be file<br>d oth   | Be         |  | it)  |                      |   |                               |  |   | ame)                    |   |
| 200. Place of Deposition Name of Control Name  | yla          |  | ပ္         |  |  |                      |   |                               |  |   |                         |   |
| 200. Place of Deposition Name of Control Name  | Jar          | 2 sh<br>and<br>le m  |            |  |  |                      |   |                               |  | -                                       |                         |   |
| CEDAR HILL CEMETERY   1-4-2006   BALTIMORE, MARYLAND   CEDAR HILL CEMETERY   1-4-2006   BALTIMORE, MARYLAND   CEDAR HILL CEMETERY   1-4-2006   BALTIMORE, MARYLAND   CEDAR HILL CEMETERY   1-4-2006    |              | and<br>tealth<br>om 27   |            |  | ./MUIHER   |                      |   | XIVE .                        |  |   |                         |   |
| Physician (Indexidate Cause (Final Cause) the death. Do not enter the mode of cying, such as cardiac or respiratory arrest. Const and Death (Indexidate Staminer)  Physician (Indexidate Cause (Final Cause) the death. Do not enter the mode of cying, such as cardiac or respiratory arrest. Const and Death (Indexidate Cause) (Indexidate Cause (Final Cause) (Indexidate Cause) ( | 0            | 0 = 5  |            | 1 XBurial 2 Cremation 3  |  | cemetery,            | crematory or other pla                        |                               |  |   | •                       |   |
| Physician (Indexidate Cause (Final Cause) the death. Do not enter the mode of cying, such as cardiac or respiratory arrest. Const and Death (Indexidate Staminer)  Physician (Indexidate Cause (Final Cause) the death. Do not enter the mode of cying, such as cardiac or respiratory arrest. Const and Death (Indexidate Cause) (Indexidate Cause (Final Cause) (Indexidate Cause) ( | tim          | tmen<br>tant:  |            |  |  | CEDAR                |   |                               |  |   |                         |   |
| Physician (Actical Examiner)    | Bal          | Departiment of the second of t |            | James q  | Morte  | in .                 | 1701-31 L                                     | AURENS                        | ST. BALT   | IMORE,                                  |                         |   |
| Due to (or as a consequence of):   |              | Physician  |            | Immediate Cause (Final   |  |                      |   | •                             | cardiac or respiratory a                           | rrest,                                  |                         | Interval Between<br>Onset and Death           |
| Sauventally, list conditions are a consequence of):  Sauventally, list conditions are a consequence of):  Sauventally list conditions are a consequence of):  Sauventally list conditions are all list of consequence of):  Sauventally list conditions are a consequence of):  Sauven |              |  |            | resulting in death)  | Due to (or as a                                    | consequence of)      |   | MORGIA                        |  |   |                         | 2 MONTHY                                      |
| Due to (br as h consequence of):    AIVS (Maywrld Immmodeficiality Syndhome)   Cause (Disease or rillury Cause or rillury Cause (Disease or rillury Cause or rillu |              | Examiner   |            | O controlly that are distance  | Emphy  | sema                 |   |                               |  |   |                         | y tows  |
| The past 12 months?    Company   Com | ,            |  | ner        | if any, leading to immediate   | Due to (or as a                                    | consequence of)      |   |                               |  |   |                         | 1   |
| FFEMALE   23c. If yes, outcome of pregnancy   1   we birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Year   23d. Date of liquid   Year   23d. Date of liquid   Year   Yea   | <b>.</b>     | executed<br>n and<br>ial-transit   | Exami      | that initiated events  | c. AIDS  Due to (or as a                           | (Acquire of)         | ld Immmod                                     | leheune                       | y Syndrom  | i)                                      |                         | years   |
| 25. Was case referred to medical examiner?  1   Yes   2   No   |              | licate be<br>physicia<br>s the bur   | edicai     |  | d  |                      |   |                               |  |   |                         |   |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | . Box        | he death certif<br>the attending<br>ched for use a   | ysician/Me | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 Mo | 1 ☐ Live birth 2<br>4 ☐ Pregnant at t              | Fetal death          |   | су                            |  |   |                         | ,   |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | Δ.           | that t<br>ed by<br>deta  | h H        | Part II. Other significant conditions                                | contributing to death bu                           | t not resulting in t | he underlying cause g                         | iven in Part I.               | 23e. Did   | tobacco use co                          | ontribute to            | the cause of death?                           |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | ds           | uires<br>s sign<br>ld be   |            |  |  |                      |   |                               | 1 🗆  | Yes 2□No                                | 3 🗆 Pro                 | bably 4 Unknown                               |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | <b>Recor</b> | e law req<br>has beer<br>je 2 shou   | mplete     |  |  |                      |   |                               | auto   | psy                                     | prior to co             | opsy findings available ompletion of cause of |
| 27. Manner of Death   28a. Date of Injury   28b. Time of Injury    | a            |  |            |  | 1  |                      |   |                               |  | -                                       | 1 🗆 Yes                 | 2 No  |
| 27. Manner of Death   28a. Date of Injury   28b. Time of Injury    | ₹            | sicia:<br>certii<br>recto  | 00         | examiner?  | Hospital:  |                      |   | than                          |  |   | 42                      |   |
| Notice   Control   Contr   | of           | 두 등 등  | <b>-</b>   |  |  |                      | atient 3 DOA                                  | 4 140                         |  |   |                         | TY)   |
| 3   Suicide determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier (Check only one)   29a. Certifier (Check only one)   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)   29c. License MATY LAND 21287   29c. Begistrar's Signature   29c. Begistrary   29c | O            | ding<br>h.<br>After<br>fune  | tion       | 1 Natural 5 ☐ Pending  | (Month, Day  | Year) Inj            |   |                               |  | . ,                                     |                         |   |
| 29a. Certifier (Check only 2) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NATURE JACKSON TORNO HOPITAL GOD NORTH WHE CREET CAUTIMORE MARYLAND 21287  | S            | deat<br>ctor:<br>y the   | fica       | 3 ☐ Suicide 6 ☐ Could not  | be 29a Place of Inju                               | ry - At home, farn   | n, street, factory, office                    | )                             |  |   | mber or Rui             | al Route Number,                              |
| 29a. Certifier (Check only 2) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NATURE JACKSON TORNO HOPITAL GOD NORTH WHE CREET CAUTIMORE MARYLAND 21287  | Š            | after<br>Dire  | erti       | 4 Homicide   |  |                      |   |                               | City or To   | wn, State)                              |                         |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NAME JANKSON JOHNS HOPKING HOPFITAL GOD NORTH WRITE CTATET BACTIMORE MARYLAND 21287  31. Date filed (Month, Day, Year)   |              | Hospita<br>24 hours<br>Funeral<br>stely filled   |            | (Check only 2 Medical Ex   | eminer: On the basis of                            | examination and/     | death occurred at the or investigation, in my | time, date an<br>opinion, dea | d place, and due to the<br>th occurred at the time | cause(s) and<br>date and plac           | manner as<br>e, and due | stated.<br>to the cause(s)                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NAME JANKSON JOHNS HOPKING HOPFITAL GOD NORTH WRITE CTATET BACTIMORE MARYLAND 21287  31. Date filed (Month, Day, Year)   |              | ompl   | Me         | 29b. Signature and title of certifier                                |  |                      | 29c. Licer                                    | nse number                    |  | 29d. Date sig                           | ned (Month              | Day, Year)                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NAME AND JOHNS HOPITAL GOD NORTH WRITE CARTIMORE MARYLAND 21287  31. Date filed (Month, Day, Year)  2. Registrar's Signature   |              | ->-0   |            | > w Ain  |  |                      | n z   | ze - 0                        | 00   | DEC EAR                                 | EA 2                    | 7 7005  |
| NAME VALLOW JOHNS HOPPITAL GOD NORTH WOLFE CTREET GALTIMORE MARYLAND 21287   |              | 2  |            |  | o completed cause of de                            | ath (Item 23a) (T    |   |                               |  | ACCRIA!                                 | C16 L                   | ., 2000                                       |
| 31. Date filed (Month, Day, Year)  |              | 9  |            |  |  |                      |   | PE CTOR                       | ET BALTIMORE                                       | MARYIM                                  | ND 21                   | 287   |
|  |              |  |            | 31. Date filed (Month, Day, Year)                                    | ■ Registra   | r's Signature        |   | 1-0                           |  | · i vici                                |                         |   |

WILLIAM THOMPSON 05-08768 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a f. nerME 0352,2/13/06 TT
State of Maryland / Department of Health and Mental Hygiene RKD 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** lliam DECEMBER 26, 2005 6:13P. I hompson /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2 F 8 214-15-427 Yrs. Director 27, 198 Mary Usual Residence of Decedent the Manyland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f ahov Examiner must be notified at Baltimore 1 € Xes 2 No **Funeral Director** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28th Street 1504 238 45A 21218 filed withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 5 No If Yes, Give Year or Dates: Hama 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 □ Yes 2 No Black Specify Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" Department of Health and Mental Hygiane. Important: If Item 27 is marked other than "natur any Injury or other traumatic avent, the Medical SARR. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student Public Schools 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 end 2 should be ဂ္ ESEM1 Jones e 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) East 28+6 Baltimure ette Mother 1504 aul Jona 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Jan.3 unitu 2006 4 ☐ Donation 5 ☐ Other (Specify) Cemetery! permit. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
CALVIN C WILLIAMS SERVICE, P.A. chrun 6 1165 BALTIMORE 10.1304 1 Pant . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Gunshot Wound to Head /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that in itiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 98 IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ò Day 4☐Pregnant at time of death Month Year 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cete hes been sig , page 2 should b Be Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of dea h?

1 Yes 2 □ No autopsy performed? After this certificate 1 Yes 2 No director 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No Certification; To 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation deeth. 2 Accident 11:17 P 1 ☐ Yes 2 📉 No Dec. 25, 2005 Subject shot self within 24 hours after deeth To the Funeral Director: completely filled in by the 6 Could not be determined 3 X Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Bural Route Number. City or Town, State) 1529 Fast 28th Street 4 Homicide Residence Baltimore, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. DECEMBER 28, 2005 person who completed cause of death (Item 23a) (Type, Print) ZABILICAL 111 PENN STREET BALTIMORE, MARYLAND 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

9 2005

**ORIGINAL** 

|             |  | 4                   | For<br>State<br>Registrar  | State of  | Maryland / De                                       | partment of F<br>Certificate of   |  |                                    | iene 05                                     | 42134  |
|-------------|--|---------------------|--|---|---|---|--|------------------------------------|---|--|
| E           | Physici  |                     | 1. Decedent's Name (First, Mic   | ddle, Last)   | To  | MPAKO   | V  | 2. Date of Dear                    | ZA OS                                       | 3. Time of Death  OZ 19 AM                   |
|             | /Medic<br>Examin   |                     | 4a. Facility Name (If not institut   | tion, give street and numb                                  | cal Certer  | 4b. City, Town, o   | r Location of Death                          |                                    | 4c. County of De                            | eath   |
| _           | Funeral  |                     | 5. Social Security Number  | 6. Sex 7.   | Age (In yrs. last birthd                            | ay) If Under 1 Year   | If Under 24 Hrs.                             | 8. Date of Birth                   | N/A<br>9. E                                 | Birthplace (State or Foreign Country)        |
|             | Director   |                     | 213-10-9169 Usual Residence of Decedent  | 1□M 2√F   | 87 Yrs  | Months Days   | Hours Min.                                   | 02/22/                             | 1918  | MD   |
|             | yland  |                     | 10a. State 10b. Cour   | nty   | 10c. City, Town o                                   | r Location  |  |                                    |   | 10d. Inside City Limits                      |
|             | Ba-f et  | ctor                |  | TIMORE  | BALTIM  |   |  |                                    |   | 1 ☐ Yes 2 No                                 |
|             | with the   | Dire                | 10e. Street and Number 31 FARMHOUS   | E COURT   |   | 10f. Zip Code 2120  | 0  | 1                                  | log. Citizen of What                        |  |
|             | Tre 23   | era                 | 11. Marital Status   | 12. Was Decede  | ent Ever in U.S.                                    | 13. Was Decedent of H<br>If Yes, specify Cuba                             |  | ecify Yes or No-                   | U.S.A.<br>14. Race - Ar                     | merican Indian,                              |
| 5-0036      | 72 hours atler death with the Maryland<br>'natural', or Heme 23a or 28a-f ehow<br>dical Examinat must be modified at | by Funeral Director | 1 ☐ Never Married 2 🛣 M<br>3 ☐ Widowed 4 ☐ Divord  | If Yes Give   | X No  | If Yes, specify Cuba  | an, Mexican, Puerto Specify:                 | Rican, etc.)                       | Black, W<br>Specify:                        | hite, etc.<br>VHITE                          |
| 5-0         | 72   | eted                | 15. Deced<br>(Specify only hig   | lent's Education<br>hest grade completed)                   | (G  | ecedent's Usual Occup<br>live kind of work done<br>le. DO NOT use retired | during most of work                          | ing                                | 16b. Kind of Busines                        | ss/Industry                                  |
| 2121        | e filed within<br>al Hygiene.<br>I other then "  | Completed           | Elementary/Secondary (0-12   | 2) College (1-4<br>5+                                       | or 5+) OWN  |   | 2)   |                                    | PHARMACY                                    |  |
|             | tal Hyg<br>d other   | BeC                 | 17. Father's Name (First, Midd   | le, Last)   |   |   | 18. Mother's Name                            | e (First, Middle, i                |   |  |
| Maryland    | Men  | 2                   | I SRAEL  | anabin (Time Print)   | MASSI   | NG<br>ailing Address (Street  | REBECCA                                      | al Cauta Mumba                     | City of Town Charles                        | KORMAN                                       |
| S S         | nd 2 sho<br>alth and<br>27 is mu<br>ir traumu  |                     | 19a. Informant's Name/Relation   |   |   | FARMHOUSE   |  |                                    | area cessooosiisiin                         |  |
| ore,        | permit. Pages I and Deparlment of Health Important: If Item 27 any injury or other tr anger.                         |                     | 20a. Method of Disposition   | on 3 Removal from St  | 20b. Place of Di                                    | sposition (Name of<br>crematory or other place                            |  |                                    | 20c. Location - City                        |  |
| Baltimore   |  |                     | 4 Donation 5 ☐ Other   | (Specify)   | BETH EL   | MEMORIAL  |  | 8/2005 F                           | RANDALLSTO                                  | WN, MD                                       |
| Bal         | permil<br>Depar<br>Impor<br>any in   |                     | 21. Signature of Funeral Servi   | John.   |   |   | SU<br>TERSTOWN                               | ROAD - F                           |   | , MD 21208                                   |
|             | Physician  |                     | 23a. Part1. Enter the disease<br>shock, or heart failure. I<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | or complications that ceu<br>ist only one cause on each     | ised the death. Do not<br>th line.<br>He Reno       | al failu  | re   |                                    | est,  | Approximate Interval Between Onset and Death |
|             | /Medical<br>Examiner   | 5                   |  | Dtie to (or   | as a consequence of):                               | roid He   | morth  | age                                |   | days   |
| ŗ.          | P ==   | ner                 | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                          | b. Due to (or   | as a consequence of):                               |   |  | J                                  |   |  |
|             | be executed<br>ician and<br>burial-transit   | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last  | c. Due to (or   | as a consequence of):                               |   |  |                                    |   |  |
| 8760,       | ate be execul<br>hysician and<br>he burial-trar  | icai E              |  | d   |   |   |  |                                    |   |  |
| 9           | certificate<br>iding phys<br>ise as the  |                     | IF FEMALE:   |   |   |   |  |                                    |   |  |
| .O. Box     | death<br>e atten   | Physician/Med       | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown   |   | h 2 Fetat death<br>nt at time of death              | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify) _                            | ·  |                                    | 23d. Date of o<br>Month                     | delivery<br>Day Year                         |
| α.          | than than  | by Ph               | Part II. Other significant cond  | litions contributing to deal                                | th but not resulting in th                          | e underlying cause giv  | ren in Part I.                               | 23e. Did tol                       | bacco use contribute                        | to the cause of death?                       |
| ords        | w requires<br>been signi<br>should be  |                     |  |   |   |   |  | 1 🗆 Y                              | es 2 No 3                                   | Probably 4 Unknown                           |
| Il Records, | The law ate has b  | Completed           |  |   |   |   |  | 24a. Was a autops perform          | med? prior t                                |  |
| Vital       | Physicien: Th<br>this certificate<br>al director, pag  | Be                  | 25. Was case referred to med examiner?   | Hospital:   |   | tiont 3 DOA Oth   | 26. Place of Deat                            |                                    |   |  |
| ō           |  | n: To               | 1 Yes 2 No 27. Manner of Death   | 28a. Date of  | Injury 28b. Tim                                     | e of 28c. Injur   | 4   Indising no                              |                                    | ence 6 Other (Spow injury occurred          | oecify)                                      |
| sion        | Attending F r death. sctor: Atter by the tuner   | atio                | Z L Modidonii  | stigation   | Day Year) Inju                                      |   | Yes 2 □ No                                   |                                    |   |  |
| Division    | spital or Att<br>ours after de<br>teral Direct<br>filled in by t   | Certification:      |  | ald not be 28e. Place of building                           | f Injury - At home, farm<br>, etc. <i>(Specify)</i> | , street, factory, office   |  | 28f. Location (Si<br>City or Town  |   | Rural Route Number,                          |
|             | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely tilled in by the           | edical              | (Check only 2 Medic  | rying Physician: To the boat Examiner: On the bas and manne | is of examination and/o                             | eath occurred at the ting of investigation, in my continuous              | me, date and place,<br>opinion, death occurr | and due to the cred at the time, d | ause(s) and manner<br>late and place, and d | as stated.<br>ue to the cause(s)             |
|             | To t<br>To the   | Σ                   | 29b. Signature and title of cert   | ty  | Rhi, M.O.   | 29c. Licens   |  |                                    | 9d. Date signed (Mo                         |  |
| 10          | ) I  |                     | 30. Name and address of personal Marklarch M. R.   | on who completed cause 22 South G                           | of death (Item 23a) (Ty                             | - Dian  |  | 201                                |   |  |
| je.         | Sta<br>Registi   |                     | 31. Date filed (Month Par Ye   | 9 2005  | or death (item 23a) (Ty                             | Sporte  |  |                                    |   |  |

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

32. Registrar's Signatures

PRIVE.

C. RIPES, N

9 2005

|                |  |                  | 1- State of Maryland / State of Maryland /  | -         | artment of Hertificate of E                     |                      | nd Ment                      |                               | iene                     | 5 4  | 2136   |
|----------------|--|------------------|---|-----------|---|----------------------|------------------------------|-------------------------------|--------------------------|--|--|
|                | Physicia   | an               | Decedent's Name (First, Middle, Last)   |           | 10/1-   | 0.1.1.0              | М                            | ate of Death                  | Day                      | Year   | 3. Time of Death<br>9:57 PM                  |
|                | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, give street and number)  |           | 4b. City, Town, or                              | eatle<br>Location of |                              | ember                         | 4c. Cou                  | 2005<br>nty of Death   | 1,00   |
| 1:             | *.*  |                  | The Johns Hopkins Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last bi  |           | Baltimo<br>If Under 1 Year                      | If Under 24          | City<br>1 Hrs. 8. Da         | ate of Birth                  | 1                        | NA<br>9 Birtho   | lace (State or Foreign                       |
|                | Funeral Director   |                  | 217-22-9449 1□M 2♥F 78  | Yrs.      | Months Days                                     | Hours                | Min. (M                      | fo <i>nth, Day,</i><br>4–30–2 |                          | Cour   | Md.  |
|                | land bw  |                  | Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow   | wn or Lo  | ocation   |                      |                              |                               |                          | 1  | 0d. Inside City Limits                       |
|                | e Mary<br>la-f sh<br>lillied   | ctor             | Md. NA E  | Balt      | imore   |                      |                              |                               |                          |  | 1 X Yes 2 No                                 |
|                | with th  | Funeral Director | 10e. Street and Number  |           | 10f. Zip Code<br>21205                          |                      |                              | 10                            | g. Citizen o<br>USA      | of What Cour   | try?   |
|                | ms 23  | eral             | 803 N. Port Street  11. Marital Status  12. Was Decedent Ever in U.S.   | 13.       | Was Decedent of His                             | spanic Origin        | n? (Specify Y                | es or No-                     | 14. F                    | lace - Americ  |  |
| 36             | be filled within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23c or 28a-f show event, the Medical Evantinet must be notified at | by Fur           | 1 Never Married 2 Married 1 Yes, Give   |           | If Yes, specify Cubar<br>1 ☐ Yes 2√2 No         | Specify:             | Puerto Hican                 | , etc.)                       |                          | llack, White,<br>c <i>ify:</i> Bla                           |  |
| 21215-0036     | 2 hours<br>atural  |                  |   | a. Dece   | dent's Usual Occupa                             |                      |                              | 1                             | 16b. Kind of             | Business/Inc   |  |
| 1215           | within 7;<br>iene.<br>than "n  | Completed        | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  | life.     | kind of work done do<br>DO NOT use retired)     |                      |                              |                               | <b>.</b> .               | C W 7  |  |
|                | filed w<br>Hygier<br>other ti  | e Col            | 8th grade  17. Father's Name (First, Middle, Last)  |           | Great Oak                                       |                      | ter<br>s Name <i>(Fir</i> si |                               |                          | of Md  | •  |
| /lan           | should be<br>nd Mental<br>markad c   | To B             | James Boul  | ldin      | ı   |                      | Irene                        |                               |                          | Ţ  | Jnkn   |
| Maryland       | od 2 ::<br>Ith ar<br>27 Is<br>r trau   | 0 0              | 19a. Informant's Name/Relationship (Type, Print)  Hattie E. Boone Cousin  |           | ng Address (Street a.<br>27 E. Madi             |                      |                              |                               | -                        |  | Code)<br>205                                 |
| altimore,      | m O .  |                  | 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State  | эгу, стөг | esition (Name of matory or other place mel Cem. |                      | Date<br>.2-30-0              |                               |                          | n - City or To   |  |
| Balti          | permit. Page<br>Department of<br>Important: if<br>any injury or<br>once.   |                  | 21. Signature of Funeral Service Licensea   |           | 2. Name and Address                             |                      | 110                          |                               |                          | e, Md.<br>n Ave.   | 21202  |
|                |  |                  | 23a Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one dause on each line.   |           |   |                      |                              |                               |                          | ,  | Approximate<br>Interval Between              |
|                | Physician  | ă 7              | Immediate Cause (Final disease of condition a. Lung Canc resulting in (eath)  | er        |   |                      |                              |                               |                          |  | Onset and Death Omonths                      |
|                | /Medical<br>Examiner   |                  | Due to (or * a consequence  | of):      |   |                      |                              |                               |                          |  |  |
| -              | p ii   | lner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clesses of Irijury)   | of):      |   |                      |                              |                               |                          |  |  |
| _6             | cate be executed physician and the burial-transit  | Examine          | that initiated events resulting in death) Last Due to (or as a consequence  | of):      |   |                      |                              | 4.44                          |                          | -  |  |
| 8760,          | ate be e   |                  | d   |           |   |                      |                              |                               |                          |  |  |
| O. Box 68      | death certifi<br>e attending I<br>id for use as  | hysiclan/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown |           | □Ectopic pregnancy<br>□ Other (specify)         |                      |                              |                               |                          | Date of delive   | ry<br>Day Year                               |
| σ.             | uires that th<br>signed by<br>d be detach  | Ω.               | Part II. Other significant conditions contributing to death but not resulting   | in the u  | nderlying cause give                            | n in Part I.         | 2                            | 3e. Did tob                   | acco use co              | ontribute to th  | e cause of death?                            |
| rds            | w requires<br>been sign<br>should be   | ed by            |   |           |   |                      | _                            | 1 🗌 Yes                       | s 2 XN0                  | 3 🗌 Prob   | abiy 4 □Unknown                              |
| Vital Records, | The lavate has   | Completed        |   |           |   |                      |                              | 4a. Was an autopsy perform    | /                        | b. Were auto<br>prior to cor<br>death?<br>1 \( \subseteq Yes | osy findings available inpletion of cause of |
| Vita           | Physician: T<br>this certificat<br>ral director, pa  | Be               | 25. Was case referred to medical examiner?  |           | Othe  | r                    | f Death (Che                 | ************                  |                          |  |  |
| of             |  | n; To            | (Admost Class Value)  | Time o    | II 3L DOA                                       | 4 🗆 INUIS            |                              |                               | nce 6 ∐0<br>w injury occ | Other (Specify<br>curred                                     | ()   |
| sior           | 별목절  | ertiflcation;    | 2 Accident investigation  | Injury    | M 1□Y   | ′es 2□No             |                              |                               |                          |  |  |
| Division       | i ji ji  | ertif            | 4 Homicide determined 28e. Place of Injury · At home, f building, etc. (Specify)  | arm, sti  | reet, factory, office                           |                      |                              | ity or Town,                  |                          | mber or Hura   | l Route Number,                              |
|                | B Hospital or<br>24 hours afte<br>Funaral Dir<br>etely filled in   | edical C         | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge one) Check only one) Certifying Physician: To the best of my knowledge and manner stated.                         |           |   |                      |                              |                               |                          |  |  |
|                | To tha Hos<br>within 24 h<br>To tha Fun<br>completely  | Me               | 29b. Signature and title of certifier   |           | 29c. License                                    |                      |                              |                               |                          | ned (Month,  |  |
| 1              | 3 1  |                  | Naveen Pemmaraju, Medical C   |           |   | - 000                | <b>5</b>                     | 1                             | Decem                    | ber 2  | 5,2005                                       |
| ~              | 1  |                  | 30. Name and address of person who completed cause of death (Item 23a)  Naveen Pemmaraju, The Johns Hopkins   |           |   | North b              | Volfestr                     | ce+ . B                       | altimor                  | e. Marv  | land 21287                                   |
|                | Sta<br>Registi   |                  | Naveen Remmaraju, The Johns Hopkins  31. Date filed (Month, Bay, Year)  DEC 9 2005  32. Registrar's spinature   | 204       |   |                      |                              |                               |                          | 7  |  |
|                |  | -                |   |           |   |                      |                              |                               |                          |  |  |

|                   | I WIIDO   |                  | For<br>State<br>Registrar  | -   | partment of Health and leartificate of Death  | Mental Hygier                        | .000                              | +2137   |
|-------------------|---|------------------|--|---|---|--------------------------------------|-----------------------------------|---|
|                   |   |                  | Decedent's Name (First, Middle, Last)  |   |   | 2. Date of Death                     |                                   | 3. Time of Death                              |
|                   | Physicia  |                  | 1 1 L L I A N  |   | WIISON  | December                             | 26, 2005                          | 5 17:50 M                                     |
|                   | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give s  | treet and number)   | 4b. City, Town, or Location of Deat   | h                                    | 4c. County of Death               |   |
|                   |   | Ψ.               | 1620 North Pulaski   | Street  | Baltimore   |                                      | N                                 | A   |
|                   | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 119 – 12 – 5344   | M 2AF 7. Age (In yrs. last birthd                             | Months Days Hours Min.  |                                      | 9. Birth                          | place (State or Foreign<br>ntry)<br>RI/LAND   |
|                   | 2   |                  | Usual Residence of Decedent  | 140.00  |   | /                                    |                                   | 10 d Janida Cita Limita                       |
|                   | anytar<br>phow  | _                | 10a. State 10b. County   | 10c. City, Town o   | Location  | 0                                    | ,                                 | 10d. Inside City Limits 1 X Yes 2 □ No        |
|                   | Ba-f  | Funeral Director | MARYLAND NIA   | 7   | MALTIMORE   | EUIT                                 | /                                 |   |
|                   | i   | O Le             | 10e. Street and Number   |   | 10f. Zip Code   | 10g.                                 | Citizen of What Cou               | ntry?   |
|                   | 23a   | ie l             | 1620 MULAS   | SKI STREET  | 2/2//   |                                      | USA                               |   |
|                   | en de   | T P              | The state of the s | Armed Forces?   | <ol> <li>Was Decedent of Hispanic Origin? (S<br/>If Yes, specify Cuban, Mexican, Puer</li> </ol>  | pecify Yes or No-<br>to Rican, etc.) | 14. Race - Ameri<br>Black, White, |   |
| 36                | or i  | by Fi            | 1 Never Married 2 Married  | 1 ☐ Yes 2 🗷 No<br>If Yes, Give                                | 1 ☐ Yes 2 No Specify:   |                                      | Specify: 2                        | . 0 1   |
| Ö                 | hour<br>ural'   | D D              | 3 ◯ Widowed 4 □ Divorced   | Year or Dates:  | and antia Haval Occupation  | 100                                  | Kind of Business (In              | ACK   |
| 215-0036          | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or items 23e or 28e-f ehow<br>the Modical Examiner must be motified at   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade   | completed) (G   | ecedent's Usual Occupation<br>live kind of work done during most of wo<br>ie. DO NOT use retired) | rking                                | . Kind of Business/Ir             | idustry                                       |
| 212               | withi<br>ene.   | Ĕ                | Elementary/Secondary (0-12)  | College (1-4or 5+)  | DOMESTIC WE   | ORKER F                              | DOMATE                            | Homes   |
| CA                | filed<br>Hygi<br>ther<br>ant,   |                  | 17. Father's Name (First, Middle, Last)  |   |   | me (First, Middle, Maid              | len Sumame)                       | 11011120                                      |
| Maryland          | s 1 and 2 should be filed within 72 hours after death with the Marylan ff Heelin and Mental Hygiene af the file m 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at | o Be             | FRANK  | WINS  | TON GOLD  | NER                                  | 400                               | PER   |
| <u>Z</u>          | 2 should be<br>and Mental<br>is marked of<br>aumatic eve  | ဥ                | 19a. Informant's Name/Relationship (Typ  |   | ailing Address (Street and Number or Ri   | ural Route Number, Cit               |                                   | ·   |
| Σa                | d 2 s<br>th ar<br>trau  |                  | Sal Mar  | MS (SISTER) 80  | 11 Che+ 43RD.   | ST BALT                              | MA MA                             | 2/2/2   |
| ą                 | 1 and 2<br>Heelth<br>tem 27<br>other tr   | 1                | 20a. Method of Disposition   | 20b. Place of Di  | sposition (Name of  | Date 20c.                            | Location - City or T              | own, State                                    |
| Baltimore,        | Pages<br>nent of I<br>int: If its   |                  | t Burial 2 ☐ Cremation 3 ☐ Re  | moval from State  | crematory or other place)   | 14 11 /                              | 2                                 |   |
| 뜶                 |   | 1                | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License   |   | 22. Name and Address of Facility  | 03-060                               | WINGSI                            | 1145,140.                                     |
| Ва                | permit. Depertrimports any injuste.   |                  | 21. Signatura of Full-brain Service Electrise  | 111 ). Minns  | JOSEPH H.   | BROWNTA                              | Z. FUNE,                          | RAL HOME                                      |
|                   |   | -                | 23a. Part1. Enter the disease, or complic  | eations that caused the death. Do not                         | enter the mode of during such as cardia   | AVE. BA                              | LTO, MO                           | Approximate                                   |
|                   |   |                  | shock, or heart failure. List only on  | e cause on each line.   |   |                                      |                                   | Interval Between                              |
|                   | nysician  |                  | Immediate Cause (Final disease or condition resulting in death)  | HYPERTONSI  | re otherselen   | tic Card                             | 10 Ulisant                        | /   |
|                   | /Medical<br>Examiner  |                  | resulting in death)  | Due to (or as a consequence of):                              |   | di                                   | sesse                             |   |
|                   |   | -                | Sequentially list conditions,  | Due to (or as a consequence of).                              |   |                                      |                                   |   |
| y                 | bed<br>isit   | Examiner         | n any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Ede to (or as a consequence or).                              |   |                                      |                                   |   |
|                   | and<br>and<br>Il-trar   | хап              | that initiated events c. resulting in death) Last  | Due to (or as a consequence of):                              |   |                                      |                                   |   |
| 8760,             | The law requires that the death certificate be executed tee has been signed by the ettending physicien and bege 2 should be detached for use as the burial-transit  | alE              |  |   |   |                                      |                                   |   |
| 387               | phys<br>the   | dical            | d  |   |   |                                      |                                   |   |
| 9 X               | that the death certifii<br>ed by the ettending p<br>detached for use as   | Physician/Me     | IF FEMALE:   | 3c. If yes, outcome of pregnancy                              |   |                                      | 23d. Date of deliv                | 90/   |
| Вох               | eath<br>etter<br>for u  | ciar             | in the past 12 months?   | 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death  | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   |                                      | Month                             | Day Year                                      |
| o                 | he d<br>the<br>ched   | ysi              | 1 □ Yes 2 🗷 No<br>9 □ Unknown  | 9□ Unknown  | o a cities (opening)  |                                      |                                   |   |
| P.0               | that t  |                  | Part II. Other significant conditions con  | tributing to death but not resulting in th                    | e underlying cause given in Part I.   | 23e. Did tobacc                      | o use contribute to t             | the cause of death?                           |
| Records,          | uires that<br>signed b<br>d be det  | Completed by     |  |   |   | 1 ☐ Yes                              | 2 No 3 Pro                        | babiy 4 dinknown                              |
| ŏ                 | w requir<br>been si<br>should   | ete              |  |   |   | 04- 146                              | 0.4h Wasa and                     | findings evalable                             |
| 3ec               | has<br>has  | ğ                |  |   |   | 24a. Was an autopsy performed        | prior to co                       | opsy findings available ompletion of cause of |
| _                 |   |                  |  |   |   | 1□ Yes 2Δ                            |                                   | 2□ No   |
| V.                | ysician: The lis certificate ha   | Be               | 25. Was case referred to medical examiner?   | ospital:  |   | ath (Check only one)                 | V                                 | CCENT   |
| of                |   | 7                | 1 X Yes 2 No 27. Manner of Death   | 1 Inpatient 2 EN/Outpa  | itient 3 DOA 4 Nursing F  | flome 5 ☐ Residence                  |                                   | fy) SCEINE                                    |
| Ë                 | Jing A  | o o              | 1 Natural 5 ☐ Pending  | 28a. Date of Injury 28b. Tim (Month, Day Year) Inju           |   | 26d. Describe now in                 | ijury occurred                    |   |
| Division of Vital | death.<br>ctor: A   | Certification;   | 2 Accident investigation 3 Suicide 6 Could not be  | 29a Plana of Injury. At home form                             |   | 28f. Location (Street                | and Number of Bur                 | al Pauta Numbar                               |
| Ξ                 | or A  | rtit             | 4 ☐ Homicide determined  | 28e. Place of Injury - At home, farm building, etc. (Specify) | , street, ractory, office   | City or Town, St                     |                                   | ar noble Number,                              |
| _                 | To the Hospital or Attending Physician: within 24 hours eller death. To the Funers Director: After this certifica   |                  | 29s: Certifier 1. ☐ Certifyling Phys   | foliate. To the heat of the immediates of                     | eath occurred at the time, date and place   | and this to the second               | del and construct as              | dated   |
|                   | Hos<br>E4 hc<br>Fun   | Medicai          |  | er: On the basis of examination and/o                         | r investigation, in my opinion, death occi  | urred at the time, date              | and place, and due t              | o the cause(s)                                |
|                   | thin the  | Me               | 29b. Signature and title of certifier  | and marrier states.   | 29c. License number   | 29d.                                 | Date signed (Month,               | Dav. Year)                                    |
|                   | £ 3 £ 8   |                  | 1 7ul 7011   | of AC   | O.C.M.E.  |                                      | ember 27,                         |   |
|                   | .V  |                  |  |   |   | Dec                                  | CHUCL 4/9                         | 2007  |
|                   | M   |                  | 30. Name and address of person who con   | mpleted cause of death (Item 23a) (Ty                         | rpe, Print)<br>Penn Street, Balt:   | imore. Mary                          | land 2120                         | )1  |
| _                 |   |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature                                     |   |                                      |                                   |   |
|                   | Sta   |                  |  | JZ. Hemsirar's Signatura :                                    | Coste   |                                      |                                   |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death RTHYear 3. Time of Death Day Physician Month 55 A M 24,200 DECEMBER ROBERTB. WEIERICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Northwest Hospital Center Randallstown Baltimore 6. Sex ★ M 2 F If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Pennsylvania 171-40-9533 Yrs Director 56 October 08, 1949 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "nature!, or items 23a or 28a-f shov the Medical Examinar must be notified at Maryland Carrol1 Sykesville 1 Yes 27 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1928 Pine Knob Road 21784 United States of America death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married X Married 1 ☐ Yes 2 ☐ No White Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Electrician Construction 12 0 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any injury or other traumatic event, since. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest M. Weierick Margorie Miller 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2) 1928 Pine Knob Road, Sykesville Harriand 21784

20b. Place of Disposition (Name of cometery, crematory or other place)

Date 20c. Location - City or Town, State <u> Anna Maria Weierick (Spouse)</u> 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 01/03/06 Baltimore, Maryland 21239 21. Signature of Funeral Service Licens 22. Name and Address of Facility Loring Byers Funeral Directors 23a. Ban. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heaf failure. List only one cause on each line.

The disease or condition resulting in death)

a. HERTY CECLULO. Heo 333 8728 Liberty Road, Randallstown, Maryalnd 21133 Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physicien and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 ☐ Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? T Yes 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injury efter death.

i Director: Aff
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours e To the Funeral C (Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the dauce(s) and manager as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 41410 ,2005 MO 30. Name and andress of person who completed cause of death (ftem 23a) (Type, Print) JOGINGER 32. Registrar's Signature MINTHLUES 31. Date filed (Month, Day, Year) State Registrar DEC 2 9 2005

Amend item#19a, perFH, C850, 1729/05 TT State of Maryland / Department of Health and Mental Hygiene 0.5 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DECEMBER 26, 2005 CLAIRE WEINSTEIN 11:03 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ATRIUM VILLAGE OWINGS MILLS BALTIMORE If Under 1 Year II Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Yrs. 79 11/14/1926 194-18-1607 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if I ten Z 1 is marked other than "nature!" or fleme 23a or 28e-1 ehow eny Injury or other traumatic event, the Medical Examiner mans. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐ Yes 2 ▼ No OWINGS MILLS BALTIMORE Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4730 ATRIUM COURT 21117 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Specify: WHITE 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) **BOOKKEEPER** CITY OF PHILADELPHIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be WEINSTEIN **JOSEPH** GERTRUDE GAMMERMAN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Perationship (Type, Print) BARBARA STEELE / NIECE 12204 LONG LAKE DRIVE - OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ROOSEVELT MEMORIALPARK 12/28/2005 TREVOSE, PA 22. Name and Address of Facility SOL LEVINSON & BROS., INC. un will ervice Lig 21. Signary 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pylmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). attending physicien and for use as the burial-transit Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Alzhermeris Disease 1 Pres 2 No 3 Probably 4 Unknown peeu cardiomyopathy 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No Coronary artery 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Assisted 2 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 (ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March L. Balret, M.O. P0058676 December 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Karen L. Babitt, M.D., 25 Main Street, Suite 200, Raisters pun, MD 21136 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Berein It sporte Registrar DEC 2 9 2005

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20c,perfH.0351 1/6/06 TT
State of Maryland 7 Department of Health and Mental Hygiene 15 1- State Registrar Amend Item #20b PEr FH G850 Gervice 45 of Peath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SHEILA 7.42 A M 29 /Medical 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Columb's Howard Lorien NUVSinf If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1□M 2□F Yrs. 228-78-6659 Director 53 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at Howard Maryland 1 ☐ Yes 2/17/No Laurel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9441 Glen Ridge Drive 20723 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 💥o Specify: Specify: White Completed by 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) . Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 2 Years Owner - Operator Gift Shop 1 and 2 should be filed Health and Mental Hygistem 27 Is marked other other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph Murphy Mary Lou Thaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Abram spouse 9441 GlenRidge Drive Laurel, Maryland Health tem 27 I 20723 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2006 Laurel ò permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery 1/3/2005Annapolis, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. accelland desh M00160 313 Talbott Avenue Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myelma. Physician muliple due h muliple myelon /Medical Due to (or as a consequence of): Examiner Stery Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical attending physic I for use as Ihe b IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan 1 ☐ Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DU053709 12/29/05 m 1) Rajine Come Suite#210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD FUX Calland

Registrar DHMH 17 Rev 1/2001

State

CHAWLA

2005

DEC 3 0

31. Date filed (Month, Day, Year)

14300

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene O E

|            |  |                | 1 - For State Registrer   | State of M  | Ce                           | rtificate of D                               |  |                                   | Reg. No.                                  | 42141   |
|------------|--|----------------|---|---|------------------------------|--|--|-----------------------------------|---|---|
| 77         | Physici  | an             | 1. Decedent's Name (First, Midd.  | ie, Last)   |                              |  |  | 2. Date of De<br>Month            |   | 3. Time of Death                                |
|            | /Medic   |                | Raymond Allen   |   |                              | T  |  | Dec                               | 26 200                                    | 5 4:20 AM                                       |
| 1.         | Examin   | er             | 4a. Facility Name (If not institution Union Memorial  | n, give street and number;  | ,                            | 4b. City, Town, or I                         |  |                                   | 4c. County of I                           | Death   |
| -          | Funeral  | ·* '•          | 5. Social Security Number   | 6. Sex 7. Ag  | ge (In yrs. last birthday)   | If Under 1 Year                              |  | 8. Date of Bir<br>(Month, Da      |   | Birthplace (State or Foreign                    |
| В          | Director   |                | 227-54-5811   | 1 <b>X</b> ] M 2□ F   | 65 Yrs.                      | Months Days                                  | Hours Min.                                   | 08-13-19                          |   | Country)<br>Virginia                            |
|            | and w  |                | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town or Lo        | ocation                                      |  |                                   |   | 10d. Inside City Limits                         |
|            | f sho  | 20             | MD NA   |   |                              | Baltimo                                      | ro.  |                                   |   | 1XXYes 2 No                                     |
|            | 7 28e  | Director       | 10e. Street and Number  |   |                              | 10f. Zip Code                                | 716  |                                   | 10g. Citizen of Wha                       | it Country?                                     |
|            | h with   | ai D           | 2700 N. Gilmor St   | reet  |                              | 21   | .218   |                                   | USA                                       |   |
|            | -me  | Funeral        | 11. Marital Status  | 12. Was Decedent<br>Armed Forces                                      | Ever in U.S. 13.             | Was Decedent of His<br>If Yes, specify Cuban | panic Origin? (Spe<br>, Mexican, Puerto F    | crfy Yes or No<br>Rican, etc.)    | 14. Race<br>Black \                       | American Indian,<br>White, etc.                 |
| 36         | within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or Iteme 23e or 28e-f ehow<br>ha Medical Examb ar must be routhed at  | y Fu           | 1 XNever Married 2 Mar<br>3 Widowed 4 Divorced  | rried 1 ∐ Yes 22∭2<br>If Yes, Give                                    | No                           | 1 ☐ Yes 2 No                                 |  |                                   | Specify:                                  |   |
| 21215-0036 | 2 hours  | Completed by   | 15. Deceder   | nt's Education  | 16a. Dece                    | dent's Usual Occupa                          | tion   |                                   | 16b. Kind of Busin                        | Black<br>ess/Industry                           |
| 215        | thin 7.  | pie            |   | est grade completed)  Coltege (1-4or                                  | 5+) (Give                    | kind of work done du<br>DO NOT use retired)  | iring most of workin                         | ng                                |   | •   |
| 2          | ygien<br>ygien<br>t, ne  | Соп            | Elementary/Secondary (0-12)   |   |                              | Laborer                                      |  |                                   | Bethlehem                                 | Stee1   |
| and        | iould be filed within I Mental Hygiene. Parked other then  | Be             | 17. Father's Name (First, Middle,   | (Last) unknown  |                              |  | 18. Mother's Name                            | (First, Middle,                   | Maiden Sumame).                           | unknown   |
| Maryland   | 2 should<br>and Men<br>le marke<br>sumatic   | ၉              | 19a. Informant's Name/Relations   | ship (Type, Print)  | 19b. Maili                   | ng Address (Street a                         | nd Number or Rura                            | l Route Numbi                     | er City or Town Sta                       | ite. Zin Code)                                  |
|            | and 2 sealth ar n 27 le  |                | H. Donald Bates/  |   |                              | Fairlawn Ave                                 |  |                                   |   | ,,,   |
| ore,       | of Health<br>Item 27<br>other tr   |                | 20a. Method of Disposition  | .55   | 20b. Place of Dispo          | osition (Name of<br>matory or other place    | D  | ate                               | 20c. Location - Cit                       | y or Town, State                                |
| imo        | Pages<br>ment of I<br>ant: If Its<br>ury or o  |                | 1 Burial 2 Cremation<br>4 Donation 5 Other (5   |   | Trinity Cer                  | netery                                       | 12-31-                                       | 05                                | Dundalk, 1                                | MD  |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or Iteme 23a or 28e-f ehow eny Injury or other traumatic event, the Medical Examinat ritual be notified at once. |                | 21. Signature of Funeral Service  | Licensee  | ) 6                          | 2. Name and Address<br>38 N. Gilmor          | of Facility Wylie                            | e Funera                          | 1 Home P.A.                               |   |
| 4          |  |                | 23a. Part1. Enter the disease, o  | or complications that cause   | d the death. Do not en       |  |  |                                   |   | Approximate                                     |
|            | Physician  |                | shock, or heart failure. Lis<br>Immediate Cause (Final  | t only one cause on each  | line.                        | ~ ~ ~ ~                                      |  |                                   |   | Interval Between<br>Onset and Death             |
| 1          | /Medical   |                | disease or condition resulting in death)  | Due lo (or as   | s a consequence of):         | Just S                                       |  |                                   |   | 20 days   |
|            | Examiner   |                | Sequentially list conditions  | b   | SRD or                       | n HD   |  |                                   |   |   |
|            | pg is  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as   | s a consequence of):         |  |  |                                   |   |   |
|            | xecuti<br>and<br>al-tran   | хап            | that initiated events<br>resulting in death) Last   | c. Due to (or as  | s a consequence of):         |  |  |                                   |   |   |
| 68760,     | lificate be executed<br>g physician and<br>as the burial-transit   | caiE           |   |   |                              |  |  |                                   |   |   |
|            | tificati<br>ng phy<br>as the   | ledicai        |   | <u>.</u>  |                              |  |  |                                   |   |   |
| Вох        | ith cer<br>tendin<br>or use  | an/N           | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome<br>1 ☐ Live birth                                |                              | □Ectopic pregnancy                           |  |                                   | 23d. Date o                               |   |
| .O.        | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/N    | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4□Pregnant a<br>9□Unknown   |                              | Other (specify)                              |  |                                   | Month                                     | Day Year  |
| Д          | that the ed by detacl  |                | Part II. Dther significant condit   | ions contributing to death  | but not resulting in the u   | underlying cause give                        | n in Part I.                                 | 23e. Did t                        | obacco use contribu                       | ite to lhe cause of death?                      |
| Records,   | quires<br>n sign   | d by           |   |   |                              |  |  | 10                                | Yes 2□No 3[                               | Probably 4 Donknown                             |
| O          | sw requir<br>s been si<br>s should   | Completed      |   |   |                              |  |  | 24a. Was                          |   | re autopsy findings available                   |
| Re         | The la   | mo             |   |   |                              |  |  | autor<br>perfo                    | rmed? dea                                 | r to completion of cause of<br>th?<br>Yes 2□ No |
| Vital      | slen:<br>artifica<br>ctor, p   | Be             | 25. Was case referred to medica   | al  |                              |  | 26. Place of Death                           |                                   |   |   |
| of V       | Physicien:<br>this certific<br>ral director,   | ၉              | 1 Yes 2 No  | Hospital:   |                              |  | 4   Nursing non                              |                                   | dence 6 Other                             | (Specify)                                       |
| nc         | ting<br>After<br>fune  | ilon:          | 27. Manner of Death  1 Natural 5 Pendi  |   | ay Year) 28b. Time of Injury | Work   | at<br>?<br>es 2 □ No                         | 28d. Describe                     | how intury occurred                       |   |
| Division   | Attending r death. ector: After by the fune  | fical          | 3 ☐ Suicide 6 ☐ Could   | mined   280. Place of If  | njury - At home, farm, st    |  |  | 28f. Location (                   | Street and Number of                      | or Rural Route Number,                          |
| Ö          | s after<br>s after<br>al Dire  | Certification: | 4 Homicide  | building, e   | tc. (Specify)                | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,      |  | City or To                        | wn, State)                                |   |
|            | To the Hospital or Attent<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the  | Medicai        | 29a. Certifier 1 Certifyi (Check only one)  | ing Physicien: To the bes<br>I Exeminer: On the basis<br>and manner s | or examination and/or in     | th occurred at the time                      | e, date and place, a<br>inion, death occurre | and due to the<br>ed at the time, | cause(s) and manne<br>date and place, and | er as stated. due to the cause(s)               |
| •          | within To the To the comple  | Mec            | 29b. Signalure and tilte of certific  | 1   | 19150.                       | 29c. License                                 | number                                       |                                   | 29d. Date signed (A                       | Nonth, Day, Year)                               |
|            |  |                | 1   | Solla Car   | 1/= M                        | D ATZ  | 43894  | 6                                 | Dec 2                                     | 6 2005  |
|            | \  |                | 30. Name and address of person  | who completed cause of  | death (Item 23a) (Type       | , Print)                                     | 0 1 1  | 1                                 | 1. 1                                      |   |
| 4          |  |                | Sha Kev 31. Date filed (Month, Day, Year  | M Eld   | trar's Signature             | Union  | Memori                                       | al H                              | Dec 2                                     | MD  |
|            | Sta<br>Regist  |                |   | 005   | South South                  | K  |  |                                   | /   |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician Brooks December 16, 2005 6:20 AM Wayne /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital 8. Date of Birth (Month, Day, Yea Dec. 16, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Year) **Funeral** Days Virginia 1944 61 Yrs 224-27-0854 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural" ~- " any linjury or other traumatic average. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 TrNo Directo Caroline Milford 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 22514 USA 15505 Frances Avenue Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: þ White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Edna Martin Clarence Lee Brooks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 854 Bowling Green, VA Edna Brooks - Mother 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12-20-05 Bowling Green, VA Greenlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice Storke Funeral Home 111 S. Main St., Bowling Green, VA 22427 and the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final "Sepsis disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine neumonia attending physician and for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? Failure Ventilator Dep-1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Cardrac Arnest 24a. Was an autopsy performed? Completed s certificate has b director, page 2 s Down's Syndrome 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: : After this certifications a funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Frysician: To the best of my knowledge, death occurred at the time, date end blace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DO1852 who completed cause of death (Item 23e) (Type, Print). MS 4203 (Decustory Rd HyatterilleMD 2078) me and address ORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2005 **Physician** 19, Reck Charles Herbert Dec. 8:14 PMM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Clinton Clinton

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year | Dec. 2, 1922 Prince George's Southern Maryland Hospital 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1(XM 2□F Months Days 83 Virginia 226-18-9757 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County rai', or items 23a or 28a-f ehow Examiner must be notified at Dunkirk MD Calvert 1 ☐ Yes 2X No Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20754 USA 2601 Winesap Court Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ģ White 3 AWidowed 4 □ Divorced "natural" or than "nature the Madical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Bailey-Spencer Hardware Chief Accounting Officer other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event 908.8. Carrie Shaner Herbert Monroe Beck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Victoria Templeton - Daughter 2601 Winesap Court Dunkirk, MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 ☐ Cremation 3 □ Removal from State Metropolitan Crematory 12-21-05 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility Tharp Funeral Home 220 Breezewood Dr. Lynchburg, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocarchal **Physician** arc Tio /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physicion: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 No 2 PNo funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ပ္ this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pendin I 1 Natural 1 ☐ Yes 2 ☐ No death. I Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Flace of Injury - At home, farm, street, factory, office unilding, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and tiple of certifie 29c. License number D28639 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7501 Surratts Rd. Clinton, MD 20735 Jacques Zephirin, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

|   |                | -  | State of Maryland / Depart   | artment of Health and M<br>rtificate of Death                                   |                                       | 9005 L                          | 2144   |
|---|----------------|--|--|---|---------------------------------------|---------------------------------|--|
|   |                | Decedent's Name (First, Middle, Last)  | ···········  |   | 2. Date of Death                      | -                               | 3. Time of Death                               |
| Physic  | ian            |  |  |   |                                       | Day Yeer 11, 2005               | 2:46 PM M                                      |
| /Medi   |                | Hal R. Bertrand  4a. Facility Name (If not institution, give str                   | rest and sumber!   | 4b. City, Town, or Location of Death  | December                              | 4c. County of Death             | 2.10 111                                       |
| Exami   | ner            | the second second second   |  | Laurel  |                                       | Prince Ge                       | orgo!  |
|   |                | 1110 Montrose Ave  |  |   | 8. Date of Birth                      |                                 |  |
| Funeral   | 1              | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday) | Months Davs Hours Min.  | (Month, Dey, Ye                       | eer) Count                      | ace (Stete or Foreign<br>try)                  |
| Director  |                | 213-58-8677 X  | 56 Yrs.  |   | Oct 16,                               | 1949   New Y                    | tork   |
| pug 🛊 🚆   |                | 10a. State 10b. County   | 10c. City, Town or Lo  | ocation   |                                       | 10                              | Od. Inside City Limits                         |
| sho   | ō              | MD Prince Ge   | omas I sums 1  |   |                                       | :                               | tx Yes 2 □ No                                  |
| he A  | Director       | MD Prince Ge  10e. Street and Number   | orge   Laurel  | 10f, Zip Code   | 100                                   | . Citizen of What Coun          | trv?   |
| Mith of Mith  | Ö              |  |  | 20707   |                                       | USA                             | •  |
| s 23  | Funeral        | 1110 Montrose Aven   | . Was Decedent Ever in U.S. 13.  |   | ocify Yes or No-                      | 14. Race - America              | an Indian                                      |
| tem tem   | l i            | 11. Maritai Otatos   | Armade Forces?   | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto | Rican, etc.)                          | Bleck, White,                   |  |
| s aft   | by F           | 1 Never Married 2 Married 3 Widowed 4 Divorced                                     | 1 XYes 2 No If Yes, Give Year or Dates:  | 1 ☐ Yes 2 ☐ No Specify:   |                                       | Specify: Who                    | ite  |
| filed within 72 hours after death with the Maryland Hygiene. thygiene. then "naturel", or items 23a or 28a-1 show out, the Mardical Examiner must be notified at  |                | 15. Decedent's Educa   |  | dent's Usual Occupation   | 161                                   | b. Kind of Business/Inc         | lustry   |
| 72  | ete            | (Specify only highest grade  | completed) (Give   | kind of work done during most of working DO NOT use retired)                    | ng                                    |                                 | ,  |
| Mithir Mithin   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)   | Disk Jockey   |                                       | Music                           |  |
| tygie tr  | ပိ             | 17. Father's Name (First, Middle, Last)  | Ζ  |   | (First, Middle, Mai                   |                                 |  |
| be fi   | Be             | Bernard Bertrand   |  |   | Bertrand                              | ,                               |  |
| Men Men Men Men Men Men Men Men Men Men   | 10             |  |  |   |                                       | Town Chats Tin                  | Cadal  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marcical Examiner must be notified at once. | 1              | 19a. Informant's Name/Relationship (Type   |  | ng Address (Street and Number or Rura   |                                       |                                 |  |
| and and balth n 27  |                | Charlotte Stern -  |  | B Glastonbury Dri   |                                       |                                 |  |
| of H rot  |                | 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re                         | 20b. Place of Disponentery, cre  | matory or other place)  | Date 200                              | c. Location - City or To        | wn, State                                      |
| Page<br>nent<br>int: ii   |                | '4 □ Donation 5 □ Other (Specify)  | Metropol   | itan Crematory 12/  | 21/05                                 | Alexandria                      | , VA   |
| Deficiency  Definite Pages Department of mportant: If it in injury or one.  | 1              | 21. Signature of Funeral Service Licenses  | 2  | 2. Name and Address of Facility Baker Swan Funer                                | ol Homo                               |                                 |  |
| Depa<br>Depa<br>Impo  |                | Muley 1- CX  | 1 VOSDECC  | P.O. Box 804 And  |                                       | 14806                           |  |
|   |                | 23a. Part1. Inter the disease, or complic  | ations that caused the death. Do not en  | ter the mode of dying, such as cardiac of                                       | or respiratory arrest                 | ,                               | Approximate<br>Interval Between                |
| Same Same   |                | hock, it heart failure. List only one immediate cause (Final                       | cause on each line.  | . Cardiovascular  | 11-1+                                 | Disease                         |  |
| Physician<br>/Medical   |                | disease or condition resulting in death)   | Due to (or as a consequence of):   | CANSIST 45C4 an   | 3 11 000                              | 3 /3 C43 C                      | ,  |
| Examine   |                |  | Due to (or us a consequence or).   |   |                                       |                                 |  |
|   | 9              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequence of):   |   | 1                                     |                                 |  |
| pet<br>nsit   | in             | Cause Disease of Injuly  |  |   | ,                                     |                                 |  |
| ou,<br>be executed<br>icien and<br>burial-transit   | Examiner       | that initiated events c. resulting in death) Last                                  | Due to (or as a consequence of):   |   |                                       |                                 |  |
| BOX BOYOU,<br>auth certificate be executed<br>attending physicien and<br>for use as the burial-transit  | calE           |  |  |   |                                       |                                 |  |
| ificate<br>g phys   | g              | d.   |  |   |                                       |                                 |  |
| Se as   | Physician/Medi | IF FEMALE: 23  | c. If yes, outcome of pregnancy  |   |                                       | 23d. Date of delive             | arv  |
| DOX<br>auth cer<br>attendir<br>for use  | lan            | in the past 12 months?   | 1 Live birth 2 Fetel death 3   | ☐Ectopic pregnancy<br>☐ Other (specify)   |                                       | Month                           | Day Year                                       |
| bed bed   | ysic           | 1 Yes 2 No<br>9 Unknown  | 9□ Unknown   |   |                                       |                                 |  |
| res that the de signed by the a   |                | Part II. Other significant conditions conf   | ributing to death but not resulting in the   | underlying cause given in Part I.   | 23e. Did tobac                        | cco use contribute to th        | ne cause of death?                             |
| VICAL MECONDS, P.O. DOX 00/ incien: The law requires that the death certificate certificate has been signed by the attending phys rector, page 2 should be detached for use as the  | l by           |  |  | . •   | 1 ☐ Yes                               | 2 No 3 Prob                     | abiy 4 Ohknown                                 |
| w require<br>been si<br>should b  | Completed      |  |  |   | T                                     |                                 | # # 15 L                                       |
| fec<br>e law<br>has b   | n je           |  |  |   | 24a. Was an<br>autopsy<br>performe    | prior to con                    | psy findings available<br>mpletion of cause of |
| @ ~_  | Ö              |  |  |   |                                       | No 1 ☐ Yes                      | 2 No   |
| VICION: The icion: The cortificate rector, pag  | Be (           | 25. Was case referred to medical examiner?   |  |   | n (Check only one)                    |                                 |  |
| OT VITAL Physicien: this certificate it director, a   | 10             | 1 Yes 2 No   | ospital: 1   Inpatient 2   ER/Outpatie   | ont 3 DOA Other: 4 Nursing Ho   | me 5⊟Residend                         | ce 6 ☐Other (Specify            | y)   |
|   |                | 27. Manne of Death 1 □Natural 5 □ Pending  | 28a. Date of Injury 28b. Time ( (Month, Day Yeer) Injury                                       | of 28c. Injury at Work?   | 28d. Describe how                     | injury occurred                 |  |
| ISION<br>Mitendir<br>death.<br>ctor: Af<br>y the fur  | atlo           | 2 Accident investigation   |  | M 1 ☐ Yes 2 ☐ No  |                                       |                                 |  |
| UIVISION for Attending after death. Diractor: Afte  | Certification: | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home, farm, s building, etc. (Specify)                               | treet, factory, office  | 28f. Location (Stree<br>City or Town, | et and Number or Rura<br>State) | l Route Number,                                |
| s after of in bed in  | Se             |  |  |   |                                       |                                 |  |
| LIV To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in by  |                |  | ician: To the best of my knowledge, dea<br>er: On the basis of examination and/or in           |   |                                       |                                 |  |
| ha H<br>in 24<br>ha F<br>plete  | Medical        | one)   | and manner stated.   |   |                                       |                                 |  |
| To T<br>To I  | Σ              | 29b. Signature and title of certifier  | 11-+   | 29c. License number   |                                       | I. Date signed (Month,          | -  |
| -1  |                | Harrido /y   | wyw Do   | Print) Dryra Co   | 1 1                                   | ecember.                        | 15, 2005                                       |
| 3   |                | 30. Name and address of person who con   | mpleted cause of death (Item 23a) (Type  | , Print)  | - 12                                  |                                 | (85)   |
| 2   |                | SALVAdor Sylve   | Ter 300/ Hospil  | tal or/va do  | very                                  | THY LAND                        | Ł  |
|   | tate           | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature  | Darkens.  | 01                                    |                                 |  |
| Regis   | trar           | DEC 3 0 20   | 15 Balletin St. P.   |   |                                       |                                 |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Dec tonley J. Bushneck 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Futute Care Cherrywood Nursing Home Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 12 M 2 F Months Days CO7-12-4228 Usual Residence of Decedent Director Pennsylvania 1913 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ont: If item 27 ie marked other then "naturel", or iteme 23e or 28e-f ehow 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23e or 28a-f ehov the Medical Examerar must be rectilled at Completed by Funeral Director 1 X Yes 2 ☐ No Florida Palm Beach Boynton Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4774-B Storkwood U.S.A. 33436 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Engineer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Walter Bushneck Anna Schelah ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 340 Bonnie Meadow Circle Reisterstown, MD Michael Bushneck (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of F Importent: If its eny injury or ot once. cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 Removal from State Assumption Cemetery 12/14/05 4 ☐ Donation 5 ☐ Other (Specify) Syracuse, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Giminski-Wysocki Funeral Home 1320 W. Genesee St., Syracuse, NY 13204 mure 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final Physician disease or condition resulting in death) Deme- 1-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cerebro basevia Direas Examiner Dire to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy detached for Month Day 4☐ Pregnant at time of death 5 Cher (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 22 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury Natural 5 Pending investigation within 24 hours after death.
To the Funerei Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 129085 alen I chance DECKMAL 10 2005 30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
DEC 3 0 2005

DHMH 17 Rev 1/2001

5310

Registrar's Signature

OID COURT

21133

|                      |  |                | 1 - For State Registrar  | State of M  |                | d / Depa                    |   | t of H         | ealth a                  |                       | ental Hy                        | _               | 5 4                           | 2146   |
|----------------------|--|----------------|--|---|----------------|-----------------------------|---|----------------|--------------------------|-----------------------|---------------------------------|-----------------|-------------------------------|--|
|                      |  |                | 1. Decedent's Name (First, Middle, La  | ast)  |                |                             |   |                |                          |                       | 2. Date of Dea                  | ath<br>Day      | Vass                          | 3. Time of Death                                   |
|                      | Physicia   |                | LUCILLE  | T. BROWN  |                |                             |   |                |                          |                       | Decembe                         |                 | Year<br>2005                  | 4:30 p <sup>M</sup>                                |
|                      | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, gir   | ve street and number,   | )              |                             | 4b. City,                               | Town, or       | Location o               | f Death               |                                 |                 | ity of Death                  |  |
|                      | Examin   |                | RUXTON HEALTH  | & REHAB   | CENTER         | 3                           | В                                       | ALTI           | MORE                     |                       |                                 | BAI             | TIMOR                         | E  |
|                      | Funeral<br>Director  |                | 5. Social Security Number 6.   |   |                | ast birthday)               | If Under<br>Months                      | 1 Year<br>Days | If Under:<br>Hours       | 24 Hrs.<br>Min.       | 8. Date of Birt<br>(Month, Da)  | y, Year)        | 9. Birthp<br>Cour<br>MAR      | elace (State or Foreign<br>htry)<br>YLAND          |
| -                    | 9  |                | Usual Residence of Decedent  |   |                |                             |   |                |                          |                       |                                 |                 |                               |  |
|                      | how  |                | 10a. State 10b. County   |   | 10c. City      | r, Town or Lo               |   |                |                          |                       |                                 |                 | 1                             | 0d. Inside City Limits                             |
| 2                    | Ba-f.  | cto            | MARYLAND N/A   | <u> </u>  |                | BALT                        | IMORE                                   |                |                          |                       |                                 |                 |                               |  |
| 3                    | or 24  | Director       | 10e. Street and Number   |   |                |                             | 10f. Zip                                |                |                          |                       |                                 | 10g. Citizen o  |                               | ntry?  |
|                      | 23e  | la             | 3000 TOWANDA A   |   | Г 209          |                             |   | 2121           |                          |                       |                                 | U.S.            |                               |  |
|                      | SEL SEL  | Funeral        | 11. Marital Status   | 12. Was Decedent<br>Armed Forces<br>1 Yes 2                       | Ever in U.S    | S. 13.                      | Was Deced<br>If Yes, spec               | lent of Hi     | spanic Ori<br>n, Mexican | gin? (Spe<br>, Puerto | cify Yes or No-<br>Rican, etc.) | - 14. R:        | ace - Americ<br>lack, White,  |  |
| 2                    | or I   | by Fu          | 1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2⁴☐<br>If Yes, Give<br>Year or Dates:                     | No             |                             | 1 Yes 2                                 | 2XCX\vo        | Specify:                 |                       |                                 | Spec            | ify: DTA                      | CV   |
| Ś                    | ural'  |                |  |   |                | 10.0                        |   |                |                          |                       |                                 |                 | БЬА                           |  |
| 2                    | z should be filed within 72 hours after death with the maryland and Mental Hygiene. Is marked other then "natural", or Items 23e or 28a-f show reumatic event, the Modical Examinational be notified at  | Completed      | 15. Decedent's E<br>(Specify only highest gi   | ducation<br>ade completed)  |                | 16a. Dece<br>(Give          | dent's Usua<br>kind of wor<br>DO NOT us | rk done d      | ation<br>during mosi     | of worki              | ng                              | 16b. Kind of    | Business/In                   | dustry   |
| 4                    | then the   | m<br>d         | Elementary/Secondary (0-12)  | College (1-4or  | 5+)            |                             | ESTIC                                   |                |                          |                       |                                 | N/A             | 7                             |  |
| V :                  | Hygie<br>Ther<br>nt, II  |                | 8th grade  17. Father's Name (First, Middle, Las   | t)  |                | DOM                         | ESTIC                                   |                | 18. Mothe                | r's Name              | (First, Middle,                 |                 |                               |  |
|                      | ntal I   | Be             | James H. Taylor  |   |                |                             |   |                |                          |                       | Weath                           |                 |                               |  |
|                      | d Me<br>nark<br>natic  | To             | 19a. Informant's Name/Relationship   |   |                | 10h Mailie                  | na Address                              | /Street        |                          |                       | I Route Numbe                   |                 | m State Zin                   | Code   |
| <u> </u>             | h an<br>7 Is r<br>7 Is r<br>treur  |                |  |   |                |                             | -                                       |                |                          |                       | Apt 209                         |                 |                               |  |
| ב<br>ע               | s 1 and 2 should be lied within 72 hours after death with the marylan if Health and Mental Hygiene. If the little and Mental Hygiene. If the marked other then "natural", or Items 23e or 28a-f show other treumatic event, Ite Medical Extendion of the notified at   |                | Marie Easley/Sis   | ster  | 20b. Pi        | lace of Dispo               | sition (Nam                             | ne of          |                          |                       | ate                             | 20c. Location   |                               |  |
| 5                    | it of l  |                | 1 XBurial 2 ☐ Cremation 3 [  |   | CE             | emetery, crei               | matory or ot                            | ther place     | · 1                      |                       |                                 |                 | •                             |  |
|                      | rtmer<br>rtent<br>njury  |                | ' 4 □ Donation 5 □ Other (Special Signature of Funeral Sevice Lice   |   | DR             | UIDRID                      |   |                |                          | 01-03                 | 3-06                            | BALTI           | MORE,                         | MARYLAND   |
| מ                    | permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.  |                | 21. Signatura of Funeral Service Lice  | nsee  |                | N                           | 2. Name and<br>IILLIA<br>206 W          | M C            | BROW                     | N COL                 | MUNITY                          | FUNERA          | AL HOM                        | E P.A.   |
| F                    | Physician<br>/Medical  |                | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | ATHER   | DSC            | LERO                        | ner the mode                            | e of dying     | g, such as<br>REP        | cardiac d             | r respiratory ar                | rest,<br>AR     | Dise                          | Approximate<br>Interval Between<br>Onset and Death |
| ı                    | Examiner   |                |  | Due to (or as   | s a consequ    | ience of):                  |   |                |                          |                       |                                 |                 |                               |  |
|                      | sit an   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                    | b. Due to (or as  | a consequ      | zonce of).                  |   |                |                          |                       |                                 |                 |                               |  |
| ב<br>ב               | e be executed<br>/sician and<br>e burial-transit   | Examiner       | that initiated events<br>resulting in death) Last  | C. Due to (or as  | s a consequ    | uence of):                  | <u>.</u>                                |                |                          |                       |                                 |                 |                               |  |
|                      | physici<br>s the bu  | dical          |  | d   |                |                             |   |                |                          |                       |                                 |                 |                               |  |
| <b>X</b>             | certii<br>nding<br>use a   | /M             | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome  |                |                             |   |                |                          |                       |                                 | 23d. D          | ate of delive                 | ery  |
| <u>.</u>             | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/Med  | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  | 1□Live birth<br>4□Pregnant a<br>9□ Unknown                        |                |                             | ⊒Ectopic pre<br>∃ Other (spe            |                |                          |                       |                                 | ٨               | Month                         | Day Year   |
| Ľ                    | that t   |                | Part II. Other significant conditions  | contributing to death   | but not resu   | ulting in the u             | nderlying ca                            | ause give      | en in Part I.            |                       | 23e. Did to                     | bacco use ce    | ntribute to th                | ne cause of death?                                 |
| ה<br>מ               | sign<br>d be   | d by           |  |   |                |                             |   |                |                          |                       | 1 🗆 Y                           | es 2 No         | 3 ☐ Prob                      | ably 4 Dunknown                                    |
| cords,               | requence of the contract of th | ompleted       |  |   |                |                             |   |                |                          |                       | 24a. Was                        | an 24h          | Ware sute                     | psy findings available                             |
| ֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝֝ | has<br>has   | ldm            |  |   |                |                             |   |                |                          |                       | autop                           | sv              | prior to con<br>death?        | npletion of cause of                               |
|                      | cate   | O              |  |   |                |                             |   |                |                          |                       |                                 | rmed?<br>200 No | 1 🗆 Yes                       | 2 No   |
| ומו                  | Sertifi<br>ector   | Be             | 25. Was case referred to medical examiner?   | Hospital:   |                |                             |   | Othe           | /                        |                       | (Check only o                   |                 |                               |  |
| 5                    | hysic<br>this<br>al dir  | L<br>2         | 1 Yes 2 No   | 1 L Inpati  | - 1            | ER/Outpatier<br>28b. Time o |   | Bc. Injury     | 4 IV NU                  | 7                     | ne 5 🗌 Resid<br>28d. Describe h |                 |                               | /)   |
|                      | After<br>Uner  | lon            | 1 Natural 5 ☐ Pending  | 28a. Date of Inj<br>(Month, Da                                    |                | Injury                      | M                                       | Work           | val<br>√?<br>Yes 2⊡I     |                       | 200. Describe i                 | low injury occi | uned                          |  |
|                      | death<br>tor.  | icat           | 2 Accident investigation 3 Suicide 6 Could not   | be on Blace of la   | iuna At bo     | mo form of                  |   |                | 103 2                    | -                     | Rf Location /                   | Street and Mun  | nher or Pura                  | i Route Number,                                    |
| 2                    | or An  | Certification: | 4  Homicide determined   | 28e. Place of Ir<br>building, e                                   | tc. (Specify   | r)                          | reet, ractory                           | , once         |                          |                       | City or Tow                     |                 | nber or nbra                  | r noble repriber,                                  |
| _                    | ours a   |                | 29a. Certifier Certifying P  | husinian. To the heat   | n of mucles on | uladas dost                 | b annual a                              | at the time    |                          | d place .             | and due to the                  |                 |                               | lated  |
|                      | To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 v.  | Medical        | (Check only 2 Medical Exa  | thysician: To the best<br>iminer: On the basis of<br>and manner s | of examinat    | tion and/or in              | vestigation,                            | in my op       | oinion, dea              | th occurr             | ed at the time,                 | date and place  | nanner as si<br>e, and due to | the cause(s)                                       |
|                      | thin ithin of the omple  | Me             | 29b. Signature and title of certifier  | 0   |                |                             | 29c                                     | License        | number                   |                       |                                 | 29d. Date sign  | ned (Month,                   | Day, Year)   |
|                      | - ≯ <del>-</del> ŏ   |                | Mon  | Hal   | ele            | an                          |   | n:             | 285                      | 90-                   | -                               | 12/2            | ofm                           |  |
|                      | 3  |                | 30 Name and address of person who  | completed cause of  | death /Item    | 23a) (Tune                  | Print                                   | •              | 11                       | -4                    |                                 | 1               | 0                             |  |
|                      | )  |                | 30. Name and address of person who   | HRHAT   | V/,            | 1220                        | PAI                                     | RIR            | HEI                      | Cont                  | R A                             | VE) E           | DAG                           | o Mi)  |
|                      | Sta  |                | 31. Date filed Month, Bay Year )   | 32. Regist  | rar's Signal   | ture                        | w.                                      |                |                          |                       |                                 |                 |                               | 21208  |
|                      | Registi  | ar             |  |   | ,              |                             |   |                |                          |                       |                                 |                 |                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1234#M 2001 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 1 Year 9. Birthplace (State or Foreign Security Number Funeral 62 -1852 1 ☐ M 2 🗓 F larylano Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State or 28a-f show other traumatic evant, the McCical Examiner must be notified at 1 Yes 2 □ No Maryland Completed by Funeral Director mor 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 2 or Items 23e 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Blac 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a. Decedent's Usual Occupation. Give kind of work done during most of working ife. DO NOT use retired) College (1-4or 5+) nd Mental Hygiene. marked other than Elementary/Şecondary (0-12) Samaritan Hosp. per 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 1 and 2 should be fill Health and Mental H tsm 27 Is marked ott Be Dra ither TOK 19a. Informant's Name/Relationship (Type, Print) 515 er-17 cw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 2. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F

4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State = 5 2006 sdowne, Md permit. Page Department of Important: If any injury or LIDN 22. Name and Address of Facility
Joseph L. Russ Funeral Home, P.A.
2222 W. North Ave, Balto, Md. 21216 21. Signature of Funeral Service/Licensee Enter the disease, or complications that call or heart failure. List only one cause on ear 23a, Part1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to **Examiner** Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 Ø No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown CETTEBRAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □ No 1 Tyes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) P After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 Tes 2  $\square$  No within 24 hours after death. To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be determined Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

DEC 3 n

2005

BALTIMORE MARYUMAD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. when I ten 8 per th 8851 1-3-06 vt.
State of Maryland / Department of Health and Mental Hygiene () 5 Registrar Amend Item #12&20a&B Per FH Contilled Of Grand Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 350 **Physician** December 23 ZOCS J'immie /Medical 4b City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Memorial Sulti more Union 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthptace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Nov. 22, 1926 Months Days Hours Min. 219-16-5222 1□M 2**X**F Many and Yrs. **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Md Baltimore 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 238 2121 death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 2**XX** ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify. BKCK þ 4 Divorced 3 Widowed "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many once. Educator IZ 17. Father's Name (First, Middle, Last) Be David NER 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brookford Circle Kesville, Md. 21208 (Son 20b. Place of Disposition (Name of Druid Ridge ate 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 A Cremation 3 Removal from State 4 Donation 5 Other (Specify) Greenmount Cemetery 21. Signature of Funeral Service Licensee E.P.A. Joseph L. Balto Md. Kusa 2222 W. North Avenue Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ermina MINUTE /Medical Due to (or as a consequence of): Examiner 10 minute Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a uence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery ned by the attend detached for us 3 Ectopic pregnancy Day Year Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed res 2 No 1 🗌 Yes 1 Yes 2 No funeral director, 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To SIU 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 THomicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DECEMBER 23 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MemorialHosp MARITA MIKEMO Union 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 3 0 2005 Registrar

8760, December 27, 25 Pm. Baltimore, Maryland 21215-0036

Bruce, Mildred Division of Vital Records, P.O. Box 68760

|  | 1 - State<br>Registrar  | State of Mar   |   | artment of H   | ealth and N  |   | giene (  |  | +2149  |
|--|---|--|---|--|--|---|--|--|--|
|  | Registrar     Decedent's Name (First, Middle, Lase)   | - 41   | Ce  | Tuncate of t   | Jeani  | 2. Date of De   | Reg. No.   |  | 1 1 -  |
| an                                       |   | ,  |   |  |  | Month 12  | 2 7 Day  | 2005   | 3. Time of Death   |
| al                                       | Mildred   | Hal  | <u>. l</u>  | Bru  |  | 12  |  |  |  |
| Ç.                                       | 4a. Facility Name (If not institution, give   |  |   | 4b. City, Town, or   | Location of Death  |   |  | unty of Death  |  |
|  | Gilchrist Hosp:   | ice  |   | Tows   |  |   | В  | altim  | nore   |
|  | 5. Social Security Number 6. S  |  | In yrs. last birthday)  | Months Days  | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Bi<br>(Month, D  | av. Year)  | 9. Birth   | place (State or Fore   |
|  | 212-10-00/0   | □M <b>*</b> **** 8   | 36 Yrs.   |  |  | 04 1  | 6 19   |  | MD   |
| -  | Usual Residence of Decedent  10a, State 10b, County   |  | On City Town and  |  |  |   |  |  |  |
| _  |   | '  | Oc. City, Town or Lo  |  |  |   |  |  | 10d. Inside City Lim   |
| Director                                 | MD NA   |  | Baltim  | nore   |  |   |  |  | 1 ¥ Yes 2 □  |
| lre.                                     | 10e. Street and Number  |  |   | 10f. Zip Code  |  |   | 10g. Citizen   | of What Cou  | intry?   |
|  | 1927 Hillenwood   | d Road   |   | 2.   | 1239   |   | U  | .S.A.  |  |
| Funerai                                  | 11. Marital Status  | 12. Was Decedent Eve<br>Armed Forces?  | er in U.S. 13.  | Was Decedent of Hi<br>If Yes, specify Cuba   | spanic Origin? (Sp                                       | ecity Yes or N  | o- 14. I   | Race - Ameri   |  |
| 3  | 1 Never Married 2 Married   | 1 ☐ Yes 2 No   |   |  |  | nican, etc.)  | 1  | Black, White   |  |
| <u>۾</u>                                 | 3 Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:   |   | 1 ☐ Yes 2 No   | Specify:   |   | Spe  | ecify: Bl  | lack   |
| ted                                      | 15. Decedent's Ed   | ducation   | 16a. Dece   | dent's Usual Occupa  | ition  |   | 16b. Kind o  | of Business/Ir   | ndustry  |
| Pie                                      | (Specify only highest gra   | College (1-4or 5+)   | (Give   | kind of work done of<br>DO NOT use retired   | <i>juring</i> most of <i>work</i><br>)                   | ang   |  |  |  |
| Completed                                | 9th grade   | na   | Nur   | sing As  | eistant  |   | Kogu   | ick N  | Jusing H   |
| 0  | 17. Father's Name (First, Middle, Last)   |  | NUL   | SING AS.   | 18. Mother's Nam   | e (First, Middle  |  |  | iusing n   |
| 00                                       | Tobo Us 11  |  |   |  | Marer M.   | - 44  |  |  |  |
| F  | John Hall  19a. Informant's Name/Relationship (1)   | Type Print)  | 19h Maili   | ng Address (Street a   | Mary Ma  |   | er City or To  | um Stato 7i  | in Code)   |
|  |   | W 101  |   |  |  |   |  |  | ,  |
|  | Margaret Cherry 20a. Method of Disposition  | y-Daughter   | 20b. Place of Dispo   | Hillen   | The second second  | ad, Ba<br>Date  |  |  |  |
|  | 1X Burial 2 ☐ Cremation 3 ☐   | Removal from State   | cemetery, crea  | matory or other plac   | 9)   |   |  | on - City or T   |  |
|  | 4 Donation 5 Other (Specify   | y)   | Druid   | l Ridge  | 1/4/0  | 06  | Pikes  | ville  | e, Md  |
|  | 21. Signature of Funeral Service Licen  | isee   | 22<br>M   | 2. Name and Address  | s of Facility  |   |  |  |  |
|  | * xumain  | ( ) Shund  | kt 4  | 300 Wab  | ash Ave  | , Balt  | imore  | , Md   | 21215  |
|  | 3a. Part1. Enter the disease, or complete shock, or heart failure. List only  | plications that caused th  | e death. Do not en  | ter the mode of dying  | g, such as cardiac                                       | or respiratory a  | rrest,   |  | Approximate<br>Interval Between  |
|  | Imprediate Cause (Final   | l / l . I  | 1 6   | - 64   | ~ : C  |   |  |  | Onset and Death  |
| 1  | disease or condition resulting in death)  | a. Va Vu   |   | eart (   | y iscast   |   |  |  | years  |
|  |   | Due to (or as a c  | onsequence or).   |  |  |   |  |  | 13   |
| 9  | Sequentially list conditions, if any leading to immediate   | Due to (or as a c  | onsequence of):   |  |  |   |  |  |  |
| Examiner                                 | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | •  |   |  |  |   |  |  |  |
| Xar                                      |   | C  |   |  |  |   |  |  |  |
|  | that initiated events resulting in death) Last  |  | onsequence of):   |  |  |   |  |  |  |
| 63                                       | that initiated events   | Due to (or as a c  | onsequence of):   |  |  |   |  |  |  |
| dical                                    | that initiated events   |  | onsequence of):   |  |  |   |  |  |  |
| Medical                                  | that initiated events   | Due to (or as a c  |   |  |  |   |  |  | -  |
| an/Medical                               | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant   | Due to (or as a c  | pregnancy   | <br>⊒Ectopic pregnancy   |  |   |  | Date of deliv  | -  |
| sician/Medical                           | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 \( \text{Yes} \) 2 \( \text{Ye} \) No   | Due to (or as a c d.  23c. If yes, outcome of 1 □ Live birth 2 ( 4 □ Pregnant at tin   | pregnancy<br>]Fetal death 3[  | □Ectopic pregnancy   |  |   |  | Date of deliv  | very<br>Day Year   |
| hysician/Medical                         | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 honths?  | Due to (or as a control of a c  | pregnancy<br>]Fetal death 3[  |  |  |   |  |  | -  |
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| ě  | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 thoriths? 1  Yes 2 No 9 Unknown  | Due to (or as a condition of a condi | pregnancy<br>□ Fetal death 3 [<br>ne of death 5 [   | Other (specify)  | n in Part I.   | 23e. Did  | obacco use c   | Month  | Day Year the cause of death?   |
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| To Be Completed by                       | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1  Yes 2 No 9  Unknown  Part II. Other significant conditions of the examiner? 1  Yes 2 No 27. Manner of Death  | Due to (or as a condition of the conditi | pregnancy Fetal death 3 [ ne of death 5 [ not resulting in the u  | Other (specify)  | 26. Place of Deatl                                       | 24a. Was auto perfo   | Yes 2 No   | Month  contribute to to a 3 \( \to \) Prol  b. Were autor prior to condeath?  1 \( \to \) Yes  Other (Special Control of the condeath of the c | the cause of death? bably 4 Unkno opsy findings availa ampletion of cause of   |
| To Be Completed by                       | that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1   | Due to (or as a condition of the conditi | pregnancy Fetal death 3 [ ne of death 5 [ not resulting in the u  | Other (specify) underlying cause give  | 26. Place of Deatl                                       | 24a. Whas auto performer 5 Resident                               | Yes 2 No   | Month  contribute to to a 3 \( \to \) Prol  b. Were autor prior to condeath?  1 \( \to \) Yes  Other (Special Control of the condeath of the c | the cause of death? bably 4 Junkno opsy findings availal ampletion of cause of   |
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CPM 05-08710 Robin Block

Unpend item#23,751,729,281, pinkin, Black/Indedible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year December 24, 2005 11:56 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rear of 515 South Haven Street Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days Hours 10 M 2 F 216-66-8660 50 Yrs. Director Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow th and Mental Hygiene. 27 ie marked other then "natural", or Iteme 23a or 28a-1 ehov treumstic event, the Medical Exantral must be notified at MD 1 Xes 2 No Completed by Funeral Director IMORE 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21224 permit. Pages 1 and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a any Injury or other treumatic event, the Medical Empirement 2008. 5 15.A 2. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No Baltimore, Maryland 21215-0036 f Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DISABLED DISABLED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BERI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignatur Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Combined Alcohol and Oxycodone Intoxication Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Associated with Hypothermia /Medical Due to (or as a consequence of): Examiner sit any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit ding physicien and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Cirrhosis of the liver 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes peen 24a. Was an autopsy performed 1 Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 □ res 2 □ No hes 2 ☐ No or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\times$  Other (Specify) SCENE 1XXYes 2 □ No Certification: To 28a. Date of Injury Fnd (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 □ Natural 2X Accident 5 Pending investigation Dec. 24, 2005 11:05 A M 1 ☐ Yes 2 No Found in cold environment 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Boute Num City or Town, State) Rear of 515South 4 Homicide Roadway within 24 hours a Haven Street Baltimore MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

\*\*Continuous Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner as stated.

\*\*Continuous Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) methell December 25, 2005 umorie O.C.M.E. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland MARGARIA D. KONSU 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DEC 3 0 2005



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 9:20 р. м Kathleen B. December 27, 2005 Boyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Woods Center Rosedale Baltimore Co. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 □ M 2 🂢 F 213-32-0645 70 Yrs March 14, 1935 Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, tra Medical Examinar in must be insufficial anone. 1 Yes XXNo Director Maryland Baltimore Co. Fullerton 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 4 Dunhaven Place Apt. 1C 21236 United States by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Banking 12 yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Yingling Alvin Burman <u>Christina</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Robert T. Boyer - Son 902 B Martell Court Bel Air, Maryland 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest VA Cem. Jan. 3, 2006 Garrison Forest, MD 22. Name and Address of Facility 5305 Harford Rd. Michael E. Canapp Leonard J. Ruck, Inc. Baltimore, MD 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Esophageal a Metastatic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to fur as a consequence of or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) physician P.O. Box 68760 Be Completed by Physician/Medical signed by the attending p I be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 DNo
9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, icate has been sig r, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Jein 24 a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed? Avenia 210No 1 Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Autural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Injury 5 Pending To the needs after death.

Within 24 hours after death.

To the Funeral Director; Aft 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D53465 MD dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ad DAKWOOD ROAD Glen Burnie MD 21061 7845 Moneses MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 3 0 2005

|                                       | Year II  |                  | 1 - For State Registrar  | State of Maryland / D  | epartment of Health and<br>Certificate of Death   | Mental Hyg                            | iene 05 42152   |    |
|---------------------------------------|--|------------------|--|--|---|---------------------------------------|---|----|
| #.                                    | Physic<br>/Medi  |                  | Decedent's Name (First, Midd     RITA  | fle, Last)   | BURGET  | 2. Date of Death<br>Month<br>December | Day Year  |    |
|                                       | Examin   |                  | 4a. Facility Name (If not institution  | on, give street and number)  | 4b. City, Town, or Location of Dea  |                                       | 4c. County ol Death   | _  |
|                                       |  | ¢.f              | Sinai Hos  | pital of Bettimor  |   | City                                  | N/A   |    |
|                                       | Funeral<br>Director  |                  | 5. Social Security Number 218-28-9184  | 6. Sex 1 M 2 F 7. Age (In yrs. last birth  | nday) If Under 1 Year If Under 24 Hi<br>Months Days Hours Mir                                       |                                       | 9. Birthplace (State or Foreign Country) MD   | gn |
|                                       | and  |                  | Usual Residence of Decedent  10a. State 10b. Count   | y 10c. City, Town  | or Location   |                                       | 10d. Inside City Limit  |    |
|                                       | the Marylan<br>28a-f ehow  | Funeral Director | MD N/A   | В  | ALTIMORE  |                                       | 1 X Yes 2 □ N   |    |
|                                       | with the   | Dire             | 10e. Street and Number   | F DOAD ADT F   | 10f. Zip Code   | 10                                    | Og. Citizen of What Country?  |    |
|                                       | eath w   | erai             | 3108 BANCROFT  | 12. Was Decedent Ever in U.S.  | 21215   | (Specific Ven or No                   | U.S.A.  14. Race - American Indian,   |    |
| 36                                    | hours after death with the Maryland<br>turel; or items 23s or 28s-f show<br>at Examinet must be notified at                        | by Fun           | 1 Never Married 2 Ma 3 Widowed 4 Divorce   | Armed Forces?  1 □ Yes 2 X No  | 13. Was Decedent of Hispanic Origin? (II Yes, specify Cuban, Mexican, Pue                           | arto Rican, etc.)                     | Black, White atc. WHITE Specify:  |    |
| 21215-0036                            | 72<br>E B  | Completed        | 15. Decede   | nt's Education 16a. (  | Decedent's Usual Occupation<br>Give kind of work done during most of w<br>life. DO NOT use retired) | orking 1                              | 6b. Kind of Business/Industry   | _  |
| 212                                   | f within liene.  | ошо              | Elementary/Secondary (0-12)  | College (1-4or 5+)   | AGER  |                                       | CLEANING  |    |
|                                       | e filed<br>of her<br>vent, I   | Be C             | 17. Father's Name (First, Middle   |  |   | ame (First, Middle, M                 |   |    |
| Maryland                              | should be filed<br>nd Mental Hygi<br>marked other<br>imatic event, I   | Tof              | SIDNEY   | chin (Time (Print)   | MYERBERG HAN  |                                       | GERALDINE LEVIN   | _  |
|                                       | is 1 and 2 should be filed withing Hygiene. If Health and Mental Hygiene. Item 27 is marked other then other treumatic event, Item |                  | 19a. Informant's Name/Relation   |  | Mailing Address (Street and Number or F<br>04 A FIRST STREET  |                                       |   |    |
| ore                                   | ges 1<br>t of He<br>if item<br>or oth  | - 59             | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation  | 3 Removal from State cemetery  | Disposition (Name of crematory or other place)  |                                       | Oc. Location - City or Town, State  |    |
| Baltimore,                            | permit. Pages<br>Department of<br>Important: If i<br>eny injury or one   |                  | 4 Donation 5 ☐ Other (   | Specify) DRUID R   |   | /29/2005                              | BALTIMORE, MD   |    |
| Ba                                    | permi<br>Depa<br>Impo<br>eny i   |                  | 21. Signature of Funeral Service   | Lice//see  |   |                                       | SON & BROS., INC.   |    |
| E OF                                  | Physician<br>/Medical  |                  | 23a. Part1. Enter the disease, o<br>shock, or heart lailure. Lis<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | or complications that caused the death. Do not tonly one cause on each line.  a                            | 1 Infarction  | N KUAU - Fac or respiratory arre      | PIKESVILLE, MD 21208<br>st, Approximate<br>Interval Between<br>Onset and Death                                    |    |
| * * * * * * * * * * * * * * * * * * * | Examiner posts   | miner            | Squentially list on fitnes<br>if any, leading to immediate<br>cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | b  | ):  |                                       |   |    |
| 68760,                                | eath certificate be executed<br>attending physician and<br>for use as the burial-transit   | edical Examiner  | resulting in death) Last   | Due to (or as a consequence of   | ):  |                                       |   |    |
| O. Box                                | 0 0  | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  | 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   |                                       | 23d. Date of delivery<br>Month Day Year   |    |
| rds, P.                               | quires that<br>n signed t<br>uld be deta   | d by Pi          | Part II. Other significant conditi   | ons contributing to death but not resulting in   | he underlying cause given in Part I.  |                                       | acco use contribute to the cause of death?  s 2 \( \sum \) No 3 \( \sum \) Probably 4 \( \frac{\pi}{2} \) Unknown | 'n |
| al Records,                           | : The law requires that the cate has been signed by th page 2 should be detache  | Completed        |  |  |   | 24a. Was an autopsy perform           | prior to completion of cause of   | 9  |
| Vital                                 | Physician:<br>this certifica<br>ral director, p  | Be               | 25. Was case referred to medica examiner?  | Hospital:  |   | eath Check only one                   |   |    |
| of                                    | fter file  | on: To           | 1  Yes 2 No  27. Manner of Death 1  Natural 5  Pendi   | 28a Date of Injury (Month, Day Year)  28b. Tir   | ne of 28c. Injury at work?  | Home 5 Resider 28d. Describe how      | nce 6 Other (Specify) v injury occurred   |    |
| Division                              | or Attending<br>after death.<br>Diractor: After<br>in by the fune  | Certification;   | 2 Accident Invest 3 Suicide 6 Could 4 Homicide determ  | not be nined 28e. Place of Injury - At home, farm building, etc. (Specify)                                 | M 1 ☐ Yes 2 ☐ No<br>n, street, factory, office  | 28f. Location (Stre<br>City or Town,  | eet and Number or Rural Route Number,<br>State)   | -  |
|                                       | To the Hospitei or Attendi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu         | edical Ce        | 29a. Certifier 1 Certifyir (Check only one)  | ng Physician: To the best of my knowledge,<br>Examiner: On the basis of examination and/                   | death occurred at the time, date and plac<br>or investigation, in my opinion, death occ             | e, and due to the cau                 | use(s) and manner as stated.  |    |
|                                       | To the within ? To the comple  | Med              | 29b. Signature and title ol certifie   | and mariner stated.  | 29c. License number   |                                       | d. Date signed (Month, Day, Year)   |    |
|                                       | 4  |                  |  |  | 10 D59062   | Δ                                     | ecenter 16,2005   |    |
|                                       | 0  |                  | 01 1 -   | who completed cause of death (Item 23a) (T   |   |                                       |   |    |
|                                       | Sta<br>Registr   | -                | 31. Date liled (Month, Day, Year,  | 32 Registrar's Signature   | harles  | - 144                                 | -: 4/ )   |    |

State of Maryland / Department of Health and Mental Hygiene

|  |   |  | Certificate of Death  | Reg. No  | 1005 42153  |
|--|---|--|---|--|---|
|  | Dhysisian   | 1. Decedent's Name (First, Middle, Last)   |   | 2. Dete of Deeth   | 3 Time of Death   |
|  | Physician<br>/Medical   |  |   | Month De<br>December 2   | 4, 2005 08:20 am  |
|  | Examiner  | 4e Fecility Neme (If not institution, give street end number) Ruxton House   | 4b. City, To  |  | c. County of Deeth  |
|  | Funeral<br>Director   | 5. Social Security Number 212−20−8157 6. Sex 1 M 2X F 92   | s. last birthday) If Under 1 Year If Under 1 Year Months Days Hours   |  | 9 Rirthplace (State or Foreign  |
|  | P   | Usuel Residence of Decedent  |   |  |   |
|  | Marylar<br>Fishov<br>Med at   | ly 1 1 Carolina  | city, Town or Location<br>ceensboro   |  | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No  |
|  | ofter death with the Marylar of terms 23e or 28e-f show inner must be notified at Funeral Director  | 10e. Street end Number<br>25390 Calvert Drive  | 10f. Zip Code<br>21639  |  | stizen of What Country?   |
| 020  | * F = **  | 11. Marital Status  1  Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give Yeer or Dates:  | U.S. 13. Was Decedent of Hispenic Ori<br>If Yes, specify Cuben, Mexican<br>1 ☐ Yes 2 ☒ No Specify:  |  | 14. Race - American Indian, Black, White, etc.  Specify: White                  |
| 5-0  | 72 hc   | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Decedent's Usual Occupation (Give kind of work done during most  | at of working  | (ind of Business/Industry   |
| 121  | ed within 72 hours eygiane. Nor than "natural", of the Medical Exar. Completed by   | Elementary/Secondary (0-12) College (1-4or 5+)   | (Give kind of work done during most life. DO NOT use retired)   |  | <b>2 27</b>   |
| d 2  |   |  | Homemaker 18 Mothe  | er's Name (First, Middle, Maiden                                     | Own Home  |
| an   | See See   | 100  |   | otta Roberts   | ( Sumame)   |
| ary  | shound M  | 19a. Informant's Name/Relationship (Type, Print)   | 19b. Mailing Address (Street and Number   |  | or Town, State, Zip Code)   |
| Σ  | and 2<br>alth e   | Joann Lawton, daughter   | 25390 Calvert Dri   | ve Greensboro  | MD. 21639   |
| Baltimore, Maryland 21215-0020   | Pages 1 of He mant of He mury or oth  | 20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  | Place of Disposition (Name of cametary, crematory or other place) en Haven Cemetery   | Date 20c. Lo   | ocation - City or Town, State<br>len Burnie, MD                                 |
| Balt   | pemit. Departm Importar any Inju  | 21. Signature of Euperal Service Licensee  |   | 1 Home of Lanso  |   |
|  |   | 23a. Part1. Enter the disease, or complications that caused the dea<br>shock, or heart failure. List only one ceuse on each line.                                      | th. Do not enter the mode of dying, such as   | Ferry Rd. Lans cardiac or respiratory arrest,                        | Approximate   |
| A STATE OF THE STA | Physician<br>/Medical   | Immediate Cause (Final disease or condition  |   |  | Interval Between<br>Onset and Death   |
| 13g  | Examiner  | resulting in death)  Due to (  | (or as a consequence of):   |  | MONTHS<br>KERRE YEARS   |
|  | ed Isit   | HTHEROS  | CLROTIC CARDIO  | , VASCULA )  | SERRE YEARS   |
| ે<br>જુ  | certificate be executed adding physician end use as the burial-transit arrived call examiner  | Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury c.   | or as a consequence of):  |  |   |
| 68760,   | artificate be<br>ing physicia<br>e as the bu  |  | or as a consequence of):  |  |   |
| Box  | tendii<br>or use  | 0  |   |  | I   |
|  | net the death ce<br>d by the attendi<br>letached for us:<br>Physician/  | Part II. Other significant conditions contributing to death but not res  | sulting in the underlying cause given in Part I.  | 23b. Did tobacco   | use contribute to the cause of death?   |
| s, P.O.  | as thet the death certific igned by the attending p be detached for use as by Physiciar/Mex   |  |   | 1 ☐ Yes 2  | Po No 3 Probably 4 M Unknown  |
| Vital Records,   | requir  |  |   | 24a. Was an autop performed?   | psy 24b. Were autopsy findings available prior to completion of cause of death? |
| ž<br>–   | The law ata has by paga 2 s   |  |   | 1 ☐ Yes 2  | XNo 1□Yes 2XNo  |
| /ita   | certificata<br>rector, pag  | 25. Was cese referred to medical examiner?   | 26. Place   | of Death (Check only one)  |   |
|  | Physician:<br>this certific<br>and director,  | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐   |   | rsing Home 5 - Residence   | 6 □Other (Specify)  |
| Division of  | Ing P   | 27. Menner of D-fath 1. Naturel 5 Pending 28a. Date of Injury (Month, Dey Year)  | 28b. Time of lnjury et Work?  | 28d. Describe how injury   | y occurred  |
| isi  | or Attending<br>after death.<br>Director: After<br>d in by the fune<br>ertification   | 2 Accident investigation 3 Suicide 6 Could not be  | M 1 ☐ Yes 2 ☐ N ome, farm, street, factory, office  |  | nd Number or Rural Route Number,  |
| <u>≥</u>   | To the Hespital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this centificate he completely filled in by the funeral director, page Medical Certification: To Be Com | 4 Homiciae building, etc. (Specia  | (fy)  | City or Town, State  | )   |
|  | To the Hospital within 24 hours a To the Funeral I complataly filled Medical Ce   | 29a. Certifler Check only one)  Check only one)  Certifying Physician: To the best of my known one to the basis of exeminer on the basis of exemine and manner steled. | wledge, death occurred at the time, date and<br>tion end/or investigation, in my opinion, deatl   | I place, and due to the cause(s)<br>h occurred at the time, date and | end manner as steted.  I place, and due to the cause(s)                         |
|  | vithin<br>orth<br>ompl  | 29b. Signature end title/of certifier  | 29c. License number   | 29d. Dat   | te signed (Month, Day, Yeer)  |
|  | F > F 0   | Ha. pkk/7  | 7005  | 3 094 17-  | -26-2005  |
|  | )   | 30. Name and address of person who completed cause of death (liter   | n 23a) (Type, Print)  | 7 / 7  | -26-2005<br>DERALSBURG  |
|  | 1   | PAUL M. KEINBOLD, MI   | ) 521 BLOOMING:   | DAK HUL TE   | DERALSBURG  |
|  | State   | 31. Date filed (Month, Day, Year)  32. Registrer's Signa   | ature de la constant | -  |   |

|  |                  | riease  | State of Maryla  |                          |  |   |                                | •   |                         | •                               | 1015                                     | J       |
|--|------------------|---|--|--------------------------|--|---|--------------------------------|---|-------------------------|---------------------------------|--|---------|
|  |                  | 1 - For State Registrar   | Otato of Maryto  |                          | Certificat                                     |   |                                | icitai i iy                               | Reg. No.                | UUJ                             | 4215                                     | L       |
| Physic   |                  | 1. Decedent's Name (First, Middle, La<br>Eliza beth   | Brittingham  | 1                        |  |   |                                | 2. Date of De Month                       | eath<br>25              | OS <sup>Year</sup>              | 3. Time of De                            | eath    |
| /Medi<br>Examir  |                  | 4a. Facility Name (If not institution, gr   | ve street and number)  | 0 .                      | 4b. City,                                      | Town, or Local                          |                                | 1.10                                      |                         | County of Dea                   | th                                       | /       |
| 1967   | Aller .          |   | yland Medica  50x 7. Age (In y)  |                          | 1/1.   |   | more 24 Hrs.                   | Ciry                                      |                         | 0.5:                            | 11. 1                                    | -       |
| Funeral Director   |                  |   | Sex 7. Age (In your 1 ☐ M 2 ☑ F 81   |                          | rs. Months                                     |   |                                | 8. Date of Bi                             | 192                     | 4 Mar                           | thplace (State or F<br>cuntry)<br>'Yland | -oreign |
| pu ,   |                  | Usual Residence of Decedent  10a. State 10b. County   | 100  | City Town                | or Location                                    |   |                                |   |                         |                                 |  |         |
| Aaryla<br>Fahov  | ō                | MD Baltimo  |  | nsdov                    |  |   |                                |   |                         |                                 | 10d. Inside City<br>1 ☐ Yes 2            |         |
| death with the Maryland<br>ms 23a or 28a-f show<br>fritual be notified at  | Funeral Director | 10e. Street and Number  |  |                          | 10f. Zip                                       | Code                                    |                                |   | 10g. Citi               | zen of What C                   | ountry?                                  |         |
| th with  | alD              | 328 Third Avenue  |  |                          | 212  | 227                                     |                                |   | U.S.                    | Α.                              |  |         |
| er des   | nue              | 11. Marital Status  | 12. Was Decedent Ever in<br>Armed Forces?  | U.S.                     | 13. Was Dece<br>If Yes, spe                    | dent of Hispani<br>cify Cuban, Me       | c Origin? (Sp<br>xican, Puerto | ecity Yes or N<br>Rican, etc.)            | 0-                      | 14. Race - Am<br>Black, Whi     |  |         |
| III ( Z I Z I S-0050<br>be filed within 72 hours after death with the Marylan<br>ital Hygiene.<br>Id other than "natural", or items 23s or 28s-f show<br>event, the Medical Examiner must be notified at | by F             | 1 ☐ Never Married 2 ☐ Married<br>3 ※ Widowed 4 ☐ Divorced                                       | 1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:   |                          | 1 ☐ Yes  | 28 No Spe                               | ecity:                         |   |                         | Specify: Wh                     | ite                                      |         |
| Id X IX IS-0003  If fled within 72 hours  If Hygiene.  other then "natural;  vent, the Macinal Exe   | eted             | 15. Decedent's E<br>(Specify only highest gi  | ducation<br>ade completed)   | 16a. I                   | Decedent's Usu<br>(Give kind of wo             | al Occupation                           | most of work                   | una                                       | 16b. Ki                 | nd of Business                  | /Industry                                |         |
| within no.   | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5+)   | 1                        | (Give kind of wo<br>life. DO NOT u<br>ne Maker |   |                                | g   | Ovan                    | Home                            |  |         |
| filed<br>Hygie<br>other  |                  | 17. Father's Name (First, Middle, Las   | t)   | 1101                     | ile Hakel                                      | 18. A                                   |                                | e (First, Middle                          | , Maiden                |                                 |  |         |
| chould be filled Mental Hymarked oth   | To Be            | James M. Hargett  |  |                          |  | Ne:                                     | llie V                         | . Green                                   | L                       |                                 |  |         |
| re, Indryld stand 2 should f Heelth and Men tem 27 is marke other traumatic.   |                  | 19a. Informant's Name/Relationship<br>Sandra Kramer/Dat   |  | 19b.<br>121              | Mailing Address<br>L8 Rock                     | (Street and No<br>HIII Ro               | umber or Rur<br>d. Pas         | a <i>l Route N</i> um <i>t</i><br>adena M | pe <i>r, City</i> o     | r Town, State,                  | Zip Code)                                |         |
| of Hee   |                  | 20a. Method of Disposition  | 78 11 6: :   | cemetery                 | Disposition (Nai                               | other place)                            |                                | Date                                      | 20c. Lo                 | cation - City or                | Town, State                              |         |
| Pages<br>ment of<br>ant: If its  |                  | 1 □ Burial 2 □ Cremation 3 [<br>4 □ Donation 5 □ Other (Spec                                    |  | eadwor                   | ridge Me<br>ark                                | emorial                                 | 12-2                           | 9-2005                                    | E1k                     | ridge M                         | D  |         |
| permit. Pages Depertment of important: If it any injury or o   |                  | 21. Signature of Popural Sarvice Lice   | INSORTING OF THE PROPERTY OF T |                          | Ambros   | nd Address of F<br>se Fune:<br>Hammond: | raI Hoi                        | me of L                                   | ansd                    | owne                            | 21227                                    |         |
|  |                  | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only                     | nplications that caused the de   | ath. Do n                |  |   |                                |   |                         |                                 | Approximate<br>Interval Betwe            | en      |
| Physician  |                  | tmmediate Cause (Final<br>disease or condition<br>resulting in death)                           | a Intracra   | nial                     | hemo   | orrhag                                  | re                             |   |                         |                                 | Onset and De                             | ath     |
| /Medical<br>Examiner   |                  | Testiling in deality  | Due to (or as a cons   | equence o                | f):  | 0                                       | )                              |   |                         |                                 | (  | 1       |
|  | Jer              | Sequentially list conditions, if any, leading to immediate                                      | b. Due to (or as a cons  | equence o                | f):  |   |                                |   |                         |                                 |  |         |
| ou,<br>be executed<br>icien and<br>burial-transit  | Examlner         | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c  |                          |  |   |                                |   |                         |                                 |  |         |
| e be exersicien a  | calEx            | resulting in dealin) cast   | Due to (or as a cons   | equence o                | f):  |   |                                |   |                         |                                 |  |         |
| oo /<br>ificate<br>g phys  |                  |   | d  |                          |  |   |                                |   |                         |                                 |  |         |
| BOX 00/00, eath certificate be executed attending physicien and for use as the burial-transit  | M/M              | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of preg   |                          | 3 □Ectopic p                                   |   |                                |   | 4                       | 23d. Date of de                 | livery                                   |         |
| , 6 de   | Physician/Med    | in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | 4☐ Pregnant at time of   |                          | 5 ☐ Other (sp                                  |   |                                |   |                         | Month                           | Day Yea                                  | ar      |
| uires that the signed by t   |                  | Part II. Other significant conditions   | contributing to death but not i  | esulting in              | the underlying o                               | ausa given in F                         | Part I.                        | 23e. Did                                  | tobacco u               | se contribute to                | the cause of dea                         | ıth?    |
| w requires<br>the requires<br>should be  | ed by            |   |  |                          |  |   |                                |   | _                       | A                               | robably 4 🗆 Unk                          |         |
| VII.dii necord iician: The law requir certificate has been si rector, page 2 should  | ompleted         |   |  |                          |  |   |                                | 24a. Was                                  |                         |                                 | utopsy findings ava                      |         |
| The<br>The<br>ate h  | Com              |   |  |                          |  |   |                                | perfe                                     | 22 No                   | death?                          | 2 No                                     | 30 01   |
| Of VICAL Physician: 1 rthis certifical ral director, p.  | o Be             | 25. Was case referred to medical examiner?  | Hospital:  |                          |  | Othor                                   |                                | h Check only                              |                         |                                 |  |         |
| ding Phys.  ding Phys.  After this of funeral dir.   | H-               | 1 ☐ Yes No 27. Manner of Death  | 28a. Date of Injury  | ER/Out                   |  | 28c. Injury at<br>Work?                 |                                | ome 5 Res<br>28d. Describe                |                         |                                 | icify)                                   |         |
| ending<br>auth.<br>or: Aft   | atlo             | Natural 5 Pending investigation   |  | / In                     | jury<br>M                                      | Work?<br>1 ☐ Yes                        | 2 🗆 No                         |   |                         |                                 |  |         |
| LIVISION al or Attending a after death. I Director: After d in by the fune   | Certification;   | 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined   |  | t home, far              | m, street, factor                              | y, office                               |                                | 28f. Location (<br>City or To             | Street and<br>wn, State | d Number or R<br>)              | ural Route Numbe                         | or,     |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune  | edical (         | 29a. Certifier (Check only one) Certifying P  | hysician: To the best of my liminer: On the basis of exam and manner stated.   | nowledge,<br>ination and | death occurred<br>Vor investigation            | at the time, da<br>, in my opinion,     | te and place,<br>, death occur | and due to the<br>red at the time,        | cause(s)<br>date and    | and manner as<br>place, and due | s stated.<br>a to the cause(s)           |         |
| To the To the comp   | M                | 29b. Signature and title of certifier   | mD   |                          | 29   | c. License num                          |                                |   |                         | e signed (Moni                  |  |         |
| 4  |                  | 30. Name and address of persop who  | completed cause of death (I  | tem 23a) (1              | Type, Print)                                   |   |                                |   |                         | 10-1                            |  | -       |
| 9  |                  | Julie Maya  | lothling à   | 72 5                     | 3. Gree  | ne 57                                   | . , Ba                         | thmor                                     | e                       | uD                              | 21                                       |         |
| Sta<br>Regist  |                  | 31. Date filed (Month, Day, Yeak)   | 2005   | nature                   | Bosell   |   |                                |   | ,                       |                                 |  |         |

|              |  | l              | 1 - For<br>State<br>Registrar   | S                     | State                  | of Ma                    | rylan                 |                                 | artment o   |                |                            | and M                    | lental Hy                         | giene            | ШПБ                        | any constitution of the co | 121                    | 55              |
|--------------|--|----------------|---|-----------------------|------------------------|--------------------------|-----------------------|---------------------------------|---|----------------|----------------------------|--------------------------|-----------------------------------|------------------|----------------------------|--|------------------------|-----------------|
|              |  |                | Decedent's Name (First, Middle  | . Last)               |                        |                          |                       |                                 |   |                |                            |                          | 2. Date of Dr                     | ath              |                            |  | 3. Time                | of Death        |
|              | Physici<br>/Medic  |                | ANNIE MAI   | E CC                  | PELA                   | ND                       |                       |                                 |   |                |                            |                          | Month<br>Decemb                   | er 2             |                            | 05   | 1:3                    | 5 p M           |
|              | Examin   | _              | 4a. Facility Name (If not institution   | give stre             | et and nu              | um <i>ber)</i>           |                       |                                 | 4b. City, Tow                                       | m, or          | Location o                 | f Death                  |                                   | 40               | . County of                | Death  |                        |                 |
| RIS A        |  | j.<br>P        | 5118 NELSON A   | 4VENU                 | JE                     |                          |                       |                                 |   |                | MORE                       |                          |                                   |                  | N/A                        |  |                        |                 |
|              | Funeral  |                | 5. Social Security Number   | 6. Sex<br>1 □ M       | 1 2 <b>1</b> 27 F      | 7. Age                   | (In yrs. I            | ast birthday)                   | If Under 1 You<br>Months Da                         | ear<br>ays     | If Under 2<br>Hours        | 24 Hrs.<br>Min.          | 8. Date of Bi<br>(Month, Di       | rth<br>ay, Year) | 9                          | 9. Birthpi<br>Coun   | lace (State            | e or Foreign    |
| · Æ          | Director   |                | 213-40-0992 Usual Residence of Decedent   |                       |                        |                          | č                     | 94 Yrs.                         |   |                |                            |                          | JUNE 2                            | 4 19             | 11                         | SOU!   | CH CA                  | ROLINA          |
|              | and ow   |                | 10a. State 10b. County  |                       |                        |                          | 10c. City             | , Town or Lo                    | cation  |                |                            |                          |                                   |                  |                            | 1  | 0d. Inside             | City Limits     |
| :            | Mary<br>1 sh   | ţō             | MARYLAND N/A  | 4                     |                        |                          |                       | В                               | ALTIMOR   | E              |                            |                          |                                   |                  |                            |  | 1 🛚 Y                  | es 2 No         |
|              | r 28a  | Director       | 10e. Street and Number  |                       |                        |                          |                       |                                 | 10f. Zip Cod  |                |                            |                          |                                   | 10g. Ci          | tizen of Wh                | at Coun  | try?                   |                 |
|              | 23a o  |                | 5118 NELSON A   | AVENU                 | JΕ                     |                          |                       |                                 |   | 21:            | 215                        |                          |                                   | TT               | .S.A.                      |  |                        |                 |
|              | oos<br>Lus   | Funeral        | 11. Marital Status  | 12.                   | Was Dec                |                          | ver in U.             |                                 | Was Decedent  | of His         | spanic Orio                | gin? (Spe                | ecify Yes or No                   | T                | 14. Race -                 | Americ<br>White,   |                        |                 |
| 2            | or It  |                | 1 Never Married 2 Marri   | be                    | 1 ☐ Yes<br>If Yes, G   | 2XXN0                    | 0                     |                                 | 1 □ Yes 2XX   |                | Specify:                   | , , , , , , , , ,        | 1110011, 0101)                    |                  | Specify:                   |  |                        |                 |
| 3            | ural',   | d by           | 3XXWidowed 4 □ Divorced   |                       | Year or l              | Dates:                   |                       |                                 |   |                |                            |                          |                                   |                  |                            |  |                        |                 |
| 2            | nat  | Completed      | 15. Decedent<br>(Specify only highes  |                       |                        | )                        |                       | (Give                           | dent's Usual Oo<br>kind of work do<br>DO NOT use re | one di         | uring most                 | of worki                 | ng                                | 16b. K           | and of Busi                | ness/inc   | Justry                 |                 |
|              | than   | Ę.             | Elementary/Secondary (0-12) 4th grade   | - 1                   | College                | (1-4or 5+                | .)                    |                                 | SEWIFE  | 31,100,        |                            |                          |                                   | D                | RIVAT                      | יבי  |                        |                 |
| 3            | should be lied within 72 hours atter death with the Maryland ind Mental Hygiene. Ind Mental Hygiene in marked other than "natural", or Itama 23a or 28a-f show umatic event, it a Medical Exantrar must be notified at   | a)             | 17. Father's Name (First, Middle, I   |                       |                        |                          |                       | 1100.                           | OHWITH  |                | 18. Mothe                  | r's Name                 | (First, Middle                    |                  |                            |  |                        |                 |
| 0            | lid be<br>lental<br>ked (  | To B           | HENRY BARR  |                       |                        |                          |                       |                                 |   | İ              | С                          | ARRI                     | E BROW                            | N                |                            |  |                        |                 |
| , a          |  | -              | 19a. Informant's Name/Relationsh  | пір (Туре,            | Print)                 |                          |                       | 19b. Mailir                     | ng Address (Sti                                     | reet a         | nd Numbe                   | r or Rura                | I Route Numb                      | er, City         | or Town, St                | ate, Zip   | Code)                  |                 |
| Š            | permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trat   |                | Rena C. Johnson   | ı/Dat                 | ighte                  | er                       |                       | 5118                            | Nelson  | Αv             | ve.,                       | Balt                     | imore                             | , Ma             | rvlan                      | d :  | 21215                  |                 |
| ,            | of He<br>item  |                | 20a. Method of Disposition  |                       |                        |                          | 20b. P                | lace of Dispo                   | sition (Name o                                      | f              |                            |                          | ate                               |                  | ocation - Ci               |  |                        |                 |
| ָ<br> <br> - | rages<br>nent of i<br>int: If its<br>iry or o  |                | 1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp   |                       | loval from             | State                    |                       |                                 | CEMETE  | •              | 1                          | 2-28                     | -05                               | Woo              | dlawn                      | . Ma   | rvla                   | nd              |
|              | permit. Departn Imports eny inju   |                | 21. Signature of Funeral September 1  | Kensee                |                        |                          |                       | 22                              | Name and Ad<br>ILLIAM                               | ddres          | s of Facility              | COM                      | MIINITMV                          |                  |                            |  |                        |                 |
| <u> </u>     | 8255   |                | ) / / / (F  | KRU                   | aru                    | /                        | _                     | ĭ                               | 206 W N   | OR!            | IH AV                      | ENUE                     | TIONTI                            | FUN              | EKAL                       | пОМЕ   | . P.A                  | •               |
|              |  |                | 23a. Part1 Enter the disease, or shock, or heart failure. List  | complicat             | tions that<br>cause on | caused t                 | he death              | n. Do not ent                   | er the mode of                                      | dying          | g, such as                 | cardiac o                | r respiratory a                   | rrest,           |                            |  | Approxim<br>Interval B | Between         |
| P            | hysician   |                | Immediate Cause (Final disease or condition   | 2                     | C                      | ART                      | DOL                   | IASC                            | ULAR  |                | coll                       | LAPS                     | SE.                               |                  |                            |  | Onset an               | d Death         |
|              | /Medical   |                | resulting in death)   | ( "-                  | Due to                 | (or as a                 | consequ               | uence of):                      | ·   |                |                            |                          |                                   |                  |                            |  |                        |                 |
| ľ            | Examiner   |                | Sequentially list conditions.   | b                     |                        |                          |                       | UF TI                           | TH C  | M              | NE                         |                          |                                   |                  |                            |  |                        |                 |
| 1            | sit sit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |                       | Due to                 | (or as a                 | consequ               | Jence of):                      |   |                |                            |                          |                                   |                  |                            |  |                        |                 |
|              | and<br>I-tran  | хап            | that initiated events<br>resulting in death) Last   | c                     | Due to                 | (or as a                 | consequ               | uence of):                      |   |                |                            |                          |                                   |                  |                            |  |                        |                 |
|              | cale be executed<br>physician and<br>the burial-transit  | al E           |   |                       | <b>Du</b> 0 (0         | (01 43 4                 | oonsage               | 361103 01).                     |   |                |                            |                          |                                   |                  |                            |  |                        |                 |
| 0            | phys<br>the  | dlcal          |   | d                     |                        |                          |                       |                                 |   |                |                            |                          |                                   |                  |                            |  |                        |                 |
| <            | w requires mat the death certific<br>been signed by the attending p<br>should be detached for use as   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c.                  | . If yes, ou           |                          |                       |                                 |   |                |                            |                          |                                   |                  | 23d. Date of               | of delive  | nv                     |                 |
| í :          | atter<br>of for u  | clar           | in the past 12 months?  |                       |                        | birth 2<br>nant at ti    |                       |                                 | Ectopic pregna<br>Other (specify                    |                |                            |                          |                                   |                  | Month                      |  | Day                    | Year            |
| ,            | y the  | hysl           | 9 Unknown   |                       | 9□ Unkr                | nown                     |                       |                                 |   |                |                            |                          |                                   |                  |                            |  |                        |                 |
|              | s man  | by P           | Part II. Other significant condition  |                       |                        |                          | not resu              | ulting in the u                 | nderlying cause                                     | a give         | n in Part I.               |                          | 23e. Did                          | tobacco          | use contrib                | ute to th  | e cause c              | of death?       |
| 3            | quire<br>an sig<br>uld b   | ed t           | HYPERTE   | NEI                   | 101                    | )                        |                       |                                 |   |                |                            |                          | 1 🗆                               | Yes 2            | No 3                       | ☐ Proba  | ably 4 [               | □Unknown        |
| 2            | s bee  | Completed      | GERD.   |                       |                        |                          |                       |                                 |   |                |                            |                          | 24a. Was                          |                  |                            |  |                        | as available    |
|              | te ha  | mo             |   |                       |                        |                          |                       |                                 |   |                |                            |                          | auto<br>perfe                     | ormed?           | dea                        | or to con<br>ath?<br>] Yes   |                        | f cause of      |
|              | certificate has<br>rector, page 2  | Be C           | 25. Was case referred to medical  |                       |                        |                          |                       |                                 |   |                | 26. Place                  | of Death                 | (Check only                       |                  |                            |  |                        |                 |
|              | this ce  | 70             | examiner?<br>1 Yes 2 No   | Hos                   | pital:                 | Inpatien                 | t 2 🗆                 | ER/Outpatier                    | it 3 DOA  | Othe           | r: 4□ Nui                  | rsing Hor                | ne 5 Aes                          | idence           | 6 DOther                   | (Specify   | )                      |                 |
| )<br>- 1     | fter t   |                | 27. Manne of Death 1 ☑Natural 5 ☐ Pending   |                       | 28a. Date<br>(Moi      | of Injury                | Year)                 | 28b. Time of<br>Injury          | 28c.  | Injury<br>Work | at ?                       | 3                        | 28d. Describe                     | how inju         | ry occurred                |  |                        |                 |
| 2            | eath.<br>or: A<br>the fu   | catl           | 2 Accident investig 3 Suicide 6 Could n   | ation                 |                        |                          |                       |                                 |   |                | 'es 2 □ h                  |                          |                                   |                  |                            |  |                        |                 |
|              | fter d<br>lirect<br>n by   | Certification; | 4 Homicide determi  |                       | 28e. Plac<br>build     | e of Injur<br>ding, etc. | y - At ho<br>(Specify | me, farm, str                   | eet, factory, off                                   | lice           |                            | 1                        | 28f. Location (<br>City or To     |                  |                            | or Rurai   | Route Nu               | um <i>ber</i> , |
| 4            | to the hospital or Attending Priystotalt: the law requires that the death certificate be executed. You have about the Abouts attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit. |                | 29a. Certifier 1 Certifying   | a Dhu-i-              | on: T                  | o bast if                | may be                | wieden der                      |   |                |                            |                          |                                   |                  |                            |  |                        |                 |
|              | Fun<br>Fun   | edical         | (Check only 2 Medical E   | j Physici<br>Examiner | : On the I             | basis of e<br>nner state | examinat              | wiedge, deati<br>tion and/or in | n occurred at th<br>vestigation, in r               | ny op          | e, date and<br>inion, deat | d place, a<br>th occurre | and due to the<br>ad at the time, | date an          | ) and mann<br>d place, and | er as sta<br>d due to  | ated.<br>the cause     | 9(s)            |
|              | o the  | Med            | 29b. Signature and title of certifier   | 00                    | C -A                   | sidil                    |                       |                                 | 29c. Lic  | cense          | number                     |                          |                                   | 29d. Da          | te signed (                | Month, l   | Day, Year              | )               |
| ,            | - s - o  |                | > Wan   | the.                  | Plan                   | W                        |                       | -                               | DO  | 00             | 58                         | 861                      | 0,                                | 1                | 2/2                        | 3/   | 2.00                   | 5-              |
|              | $\wedge$   |                | 30. Name and address of person v  | who come              | oleted cau             | ise of de                | ath (Item             | 23a) (Tvoe                      | Print)  |                |                            |                          |                                   |                  | -/                         | _/   | ~~~                    |                 |
|              | ,  |                | SHANN   | DH                    | TLU                    | י מט                     | NO                    | 3.                              | 333 N   | 1              | Cali                       | ur                       | 5 t                               | ۔ _              | vite                       | 5  | 5                      | *               |
| 1.4          | Sta  |                | 31. Date filed (Month, Day, Year)   | 0 -                   |                        | Registrar                | 's Signa              | ture                            | Print) 333 N  |                |                            |                          |                                   |                  |                            |  |                        |                 |
|              | - Reaistr  | ar             | DEC 9   | 11 200                | 151 1                  | D 0                      |                       | No.                             | DE AGE  |                |                            |                          |                                   |                  |                            |  |                        |                 |

|  |                 | For<br>State<br>Registrar  | State of Man   |                              | artment of He  |  | Reg. N  2. Date of Death                            | ODD ,   | 2156   |
|--|-----------------|--|--|------------------------------|--|--|---|---|--|
| Physici<br>/Medic  | _               | Decedent's Name (First, Middle, Last)  | Dorothy  | V. Coll:                     | ier  |  | Month Da<br>December                                | 24,2005   | 3. Time of Death 3:35P. M                              |
| Examin<br>Funeral  |                 | 4a. Facility Name (If not institution, give s  Good Samaritan F  5. Social Security Number  6. Sex   | Mospital   | in yrs. last birthday,       |  | timore If Under 24 Hrs. Hours Min.         | 8. Dete of Birth<br>(Month, Dey, Yeer               |   | plece (State or Foreigntry)                            |
| irector  |                 | 212-80-5519  Usual Residence of Decedent  10a. State 10b. County   | 1  | 49 Trs.  Oc. City, Town or L | ocation  |  | May23,1956  |   | vland  10d. Inside City Limit                          |
| ole ju   | ō               | Maryland   |  | ,,                           | Balti  | more                                       |   |   | 1  Yes 2 □ N   |
| or 28a   | Director        | 10e. Street and Number   | 1  |                              | 10f. Zip Code  |  | 10g. C  | itizen of What Cou  | ntry?  |
| if item 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic event. Its Modical Examinat must be notified at | Funeral         |  | tebello Te  12. Was Decedent Evo Ammed Forces?  1 Yes 211 No If Yes, Give  |                              | Was Decedent of His<br>If Yes, specify Cubar                         | 1214 spanic Origin? (Spen, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)                    | U. S. A.  14. Race - Ameri Black, White,  Specify: Talls: | etc.   |
| n "natural",<br>Aculcal Exe  | Completed by    | 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade   | Year or Dates:   | (Give                        | edent's Usual Occupa<br>e kind of work done d<br>DO NOT use retired) | tion<br>uring most of work                 |   | Kind of Business/Ir                                       | ite<br>dustry  |
| ther the   |                 | Elementary/Secondary (0-12) 6  | College (1-401 5+)   |                              | Homemaker  | 19 Mother's Name                           | (First, Middle, Maide                               | Own Home  |  |
| ked otl  | To Be           | 17. Father's Name (First, Middle, Last)  | obert Ross   | ,Sr.                         |  |  |   | rciprete  |  |
| is marked craumatic ever   |                 | 19a. Informant's Name/Relationship (Ty   | pe, Print)   | 19b. Mail                    |  |  | al Route Number, City                               |   |  |
| em 27<br>other tr  |                 | Sean P. Collier /  |  |                              | Montebello  osition (Name of omatory or other place                  | 4  | Baltimore   | e,Maryland<br>Location - City or To                       |  |
| ant: H l   |                 | 1 ☐ Burial 2 🛣 Cremation 3 ☐ R  1 ☐ Donation 5 ☐ Other (Specify)   | emoval from State  |                              | Crematory of other place   | 12/30                                      | )/05 Ba1  | .timore,M   | arvland  |
| Important: If I  |                 | 21. Signature of Funeral Service License   | en author  | 6                            | 2. Name and Addres   | mar<br>rd Road                             | zullo Fune<br>Baltimore,                            | eral Chape<br>Maryland                                    | 21214  |
| sician<br>ledical  |                 | 23a. Per1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)               | ications that caused the cause on each line.  A CATE  Due to (or as a c    | e deeth. Do not er           | nter the mode of dying  NATORY  HMA A                                | FA) Ly                                     | RE  |   | Approximate<br>Interval Between<br>Onset and Death     |
| physician and must sthe burial-transit and   | edicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a of   | consequence of):             | HMA A  | Track                                      |   |   |  |
| ned by the attending phinder of the detached for use as the  | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 万No 9 □ Unknown   | 3c. If yes, outcome of<br>1 Live birth 2<br>4 Pregnant at tir<br>9 Unknown | Fetal death 3                | □Ectopic pregnancy □ Other (specify)                                 |  |   | 23d. Date of deliv<br>Month                               | ery<br>Day Year  |
| 5 8  | ρ               | Part II. Dther significent conditions cor  | ntributing to death but  | not resulting in the         | underlying cause give  | on in Part I.                              |   | use contribute to t                                       | he cause of death?<br>pably 4 □Unknow                  |
| cate has been si<br>page 2 should t  | Completed       |  |  |                              |  |  | 24a. Was an<br>autopsy<br>performed?<br>1 ☐ Yes 2,2 | prior to co   | opsy findings availab<br>impletion of cause of<br>2 No |
| s certificate<br>director, pag   | o Be            | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital:<br>1 ☐ Inpatient   | 2 × ER/Outpatie              | ent 3 DOA Othe   | Mr.  | h (Check only one) me 5 ☐ Residence                 | 6 ∏Other (Speci   | (v)  |
| After th   | -               | 27. Manner of Death 1 XNatural 5 Pending 2 Accident Investigation  | 28a. Date of Injury<br>(Month, Day )                                       | 28b. Time                    | of 28c. Injury<br>Work   |  | 28d. Describe how inj                               |   | ,,   |
| 2 0  | Certification:  | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury<br>building, etc.                                     |                              | treet, factory, office   |  | 28f. Location (Street a<br>City or Town, Sta        |   | al Route Number,                                       |
| To the Funeral Di<br>completely filled in  | Medical         |  | sician: To the best of<br>ner: On the basis of e<br>and manner state       | xamination and/or i          |  |  |   |   |  |
| To the<br>comple   | Me              | 29b. Signature and title of certifier  | 7.4  |                              | 29c, License   |  |   | ate signed (Month,  |  |
| 0-   |                 | Frank S. S.  | chrima !   | mars.                        | DO   | 9475                                       | /.  | 2 -29-0   | 15   |
| . 5  |                 | 30. Name a address of person who co  | mpleted cause of dea   |                              | R, MA 5.   | 122 Ho                                     | yord 1  | d Ban   | Te 2121  |
| St:<br>Regist  | ate<br>rar      | 31. Date filed (Month, Day, Year) DEC 3 0 21   | 32. Pagistrar  | 7                            | 1  |  | 0   |   |  |

|                     |  |                    | 1 - For<br>State<br>Registrar   | State of Marylar  | •                      | artment o                                       |                                     | nd Mental I                              | Hygien<br>Reg. N              | 1111:                              | ) [                       | 2157                               |
|---------------------|--|--------------------|---|---|------------------------|---|-------------------------------------|--|-------------------------------|------------------------------------|---------------------------|------------------------------------|
|                     |  |                    | Decedent's Name (First, Middle, Last)   |   |                        |   |                                     | 2. Date of                               | Death                         |                                    |                           | 3. Time of Death                   |
|                     | Physici  |                    | LaVAL   | NORMAN  | CO                     | THRAN   |                                     | NOV.                                     | 28,                           | <sup>ay</sup> 200 <sup>5</sup>     | ear<br>O                  | 7:49 AM                            |
| ,                   | /Medio<br>Examir   |                    | 4a. Facility Name (If not institution, give s                                     | treet and number)   |                        | 4b. City, Tow                                   | n, or Location of                   | Death                                    |                               | c. County of                       |                           |                                    |
|                     |  |                    | Holy Cross Hos  | spital  |                        | Silv  | er Spr                              | ing                                      |                               | Monto                              | Jome                      | ry                                 |
|                     | Funeral<br>Director  |                    | 5. Social Security Number 6. Sex 194-22-9727                                      | 7. Age (In yrs. 74  | last birthday)<br>Yrs. | If Under 1 Ye<br>Months Da                      |                                     | Min. B. Date of (Month)                  | Birth<br>Day Year<br>29, 1    | 930 E                              | Birthpla<br>Countr<br>enn | State or Foreign                   |
|                     | 2 >  |                    | Usual Residence of Decedent   | 10- 0   |                        |   |                                     |  |                               |                                    |                           |                                    |
|                     | aryla<br>ehov  | _                  | MD Montgoi  |   | ty, Town or Lo         | cation<br>r Spri                                | na                                  |  |                               |                                    | 100                       | d. Inside City Limits 1 Yes 2 □ No |
|                     | 8a-f   | octo               |   | mez y   | DIIVO                  |   |                                     |  |                               |                                    |                           |                                    |
|                     | with t   | 吉                  | 10e. Street and Number  | S 2   |                        | 10f. Zip Cod                                    | <sup>le</sup><br>)902               |  | 10g. C                        | itizen of Wha                      |                           | <b>y</b> ?                         |
|                     | s 23   | ra                 | 417 Hillsboro   |   | 10 40 1                |   |                                     | 2.00 7 7                                 |                               |                                    |                           |                                    |
| 36                  | permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Importent: if Item 27 is marked other then "neturel", or Items 23e or 28e-f show with fujury or other traumatic event, I'm Medical Event, ar must be rediffied at Once. | y Funeral Director | 11. Marital Status  1 Never Married 2 🛣 Married  3 Widowed 4 Divorced             | 12. Was Decedent Ever in L<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates: |                        | was Decement<br>f Yes, specify (<br>1 ☐ Yes 2 ☐ | _                                   | n? (Specify Yes or<br>Puerto Rican, etc. | No-                           | 14. Race -<br>Black, \<br>Specify: | Amencai<br>White, et      | tc.                                |
| 8                   | hou  | Completed by       | 15. Decedent's Educ   |   | 16a Decer              | ient's Usual Oc                                 | roupation                           |  | 165                           | Kind of Busin                      |                           |                                    |
| 15                  | in 72<br>n ne  | olet               | (Specify only highest grade   | completed)  | (Give                  | kind of work do                                 | ne during most o                    | f working                                | 100. 1                        | Kiria di Basii                     | 1922/11/00                | stry                               |
| 72                  | iene.  | E                  | Elementary/Secondary (0-12)   | College (1-4or 5+)<br>12yrs   |                        | fessor  |                                     |  | НС                            | ward                               | Uni                       | versity                            |
| פ                   | filed<br>Hyg<br>other  | BeC                | 17. Father's Name (First, Middle, Last)   |   |                        |   |                                     | s Name (First, Mic                       | idle, Maide                   | n Sumame)                          |                           |                                    |
| ylar                | ould be<br>Menta<br>Arked<br>atic ev   | To B               | Walter Cottm  |   |                        |   |                                     | dna Hes                                  |                               |                                    |                           |                                    |
| Maryland 21215-0036 | nd 2 sh<br>slith and<br>27 is m<br>r traum   |                    | 19a. Informant's Name/Relationship (Ty) Mary Cothran- W                           |   | 19b. Mailir<br>417     | ng Address (Str<br>Hills                        | eet and Number o                    | or Rural Route Nu<br>Silvei              | mber, City<br>Spr             | or Town, Sta<br>Ting ,             | ite, Zip C<br>MD          | 20902                              |
| ē,                  | S 1 e  |                    | 20a. Method of Disposition  |   | Place of Dispo         | sition (Name or<br>natory or other              | f<br>place)                         | Date                                     | 20c. l                        | ocation - Cit                      | y or Tow                  | n, State                           |
| Ĕ                   | Page<br>nent c<br>nt: If   |                    | 1 Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)                 | emoval nom State  | ate of                 | Heave   | en  12                              | /05/200                                  |                               |                                    |                           | oring, MI                          |
| Baltimore,          | mit.<br>pertra<br>sorte<br>/ Inju  |                    | 21. Signature of Funeral Strvice License  | 000   | 22                     | . Name and Ad                                   | Idress of Facility                  | Snowder                                  | 1 Fur                         | neral                              | Hon                       | ne P.A.                            |
| m                   | 20E 2  | -                  | Course K  | Angalel   | _ 2                    | 46 N.   | Washin                              | gton St                                  | Roc                           | ckvil.                             | le,                       | 4D20850                            |
|                     |  |                    | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on  | cations that caused the dea   | th. Do not ent         | er the mode of                                  | dying, such as ca                   | rdiac or respirato                       | y arrest,                     |                                    |                           | Approximate                        |
|                     | Physician  |                    | Immediate Cause (Final disease or condition                                       |   |                        |   |                                     |  |                               |                                    | 6                         | nterval Between<br>Onset and Death |
| 1                   | /Medical   |                    | resulting in death)   | Due to (or as a consec  | quence of):            |   |                                     |  |                               |                                    | -                         |                                    |
|                     | Examiner   |                    |   | CIRROS  |                        |   |                                     |  |                               |                                    |                           |                                    |
|                     |  | je                 | Sequentially list conditions, if any leading to immediate cause. Enter Underlying | Due to (or as a cons  |                        |   |                                     |  |                               |                                    |                           |                                    |
|                     | cuted<br>nd<br>ransit  | Examiner           | Cause (Disease or injury that initiated events                                    | RENAL :   | FAILUF                 | RE  |                                     |  |                               |                                    |                           |                                    |
| Ó                   | en ar  | EX                 | resulting in death) Last  | Due to (or as a consec  | quence of):            |   |                                     |  |                               |                                    |                           |                                    |
| 8760,               | cate be executed<br>physicien and<br>the burial-transit  | dlcal              |   |   |                        |   |                                     |  |                               |                                    |                           | 1000000                            |
| 9                   |  | Jed                | IF FEMALE.  |   |                        |   |                                     |  |                               |                                    |                           |                                    |
| Box                 | th ce<br>tendii<br>r use   | an/                | ZOD. Was decedent pregnant  | 3c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Fet  |                        | Ectopic pregna                                  | ancv                                |  |                               | 23d. Date o                        | f delivery                | ,                                  |
| о.<br>П             | thet the death certified by the ettending I  | Physician/Me       | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 4 Pregnant at time of o   |                        | Other (specify                                  |                                     |  | -                             | Month                              | D                         | ay Year                            |
| <u>Р</u>            |  | Phy                | 9 Unknown   |   |                        |   |                                     |  |                               |                                    |                           |                                    |
| Records,            | Se G   | ē                  | Part II. Other significant conditions con   | tributing to death but not re   | sulting in the u       | nderlying cause                                 | given in Part I.                    |  | id tobacco                    |                                    |                           | cause of death?                    |
| Ö                   | w requir   | Completed          |   |   |                        |   |                                     | 24a V                                    | Vas an                        | 24h Wer                            | e autons                  | sy findings available              |
| æ                   | The lay  | E C                |   |   |                        |   |                                     | a  | utopsy<br>erformed?<br>es 2⊒N | prio                               | r to comp<br>th?          | pletion of cause of                |
| Vital               |  | ပို                | 25. Was case referred to medical  |   |                        |   | 00.01                               |  |                               | o 1 🗆                              | Yes 2                     | No -                               |
| 5                   | Physician:<br>rthis certific<br>ral director,  | To B               | evaminer?   | ospital: 1 Dopatient 2  | ] ER/Outpatien         | t 3 DOA   | Other                               | f Death Check or                         |                               | 2 DOIL (                           |                           |                                    |
| ō                   | Physical controls  |                    | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of           |   | njury at<br>Work?                   | ing Home 5 ☐ F                           |                               | b Liother (                        | Specify)                  |                                    |
| 0                   | oding:   | 렱                  | 1XXIIIatural 5 ☐ Pending<br>2 ☐ Accident investigation                            | (Month, Day Year)   | Injury                 |   | Mork?<br>I∐Yes 2∐No                 |  | •                             | ,                                  |                           |                                    |
| Division of         | I or Attending Ph<br>after death.<br>Director: After th<br>I in by the funeral   | Certification:     | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury - At h   | ome, farm, str         | eet, factory, offi                              | сө                                  | 28f. Location                            | n_(Street a                   | nd Number o                        | or Rural F                | Route Number,                      |
| á                   | al or  | Sert               | 4 [] Homicide   | building, etc. (Speci   | <b>(y</b> )            |   |                                     | City or                                  | Town, Stat                    | re)                                |                           |                                    |
|                     | To the Hospital or At within 24 hours after d To the Funaral Direct completely filled in by  | Medical C          | (Check only 2   Medical Examin  | ician: To the best of my kn   | owledge, death         | occurred at th                                  | e time, date and pay opinion, death | place, and due to occurred at the tir    | the cause(s                   | s) and manne                       | er as stat                | ed.                                |
|                     | the The  | Med                | one)  29b. Signature and title of certifier                                       | and manner stated.  |                        |   |                                     |  |                               |                                    |                           |                                    |
|                     | 5 t 5  |                    | 250. Signature and title of certifier   | 1611  | 0,                     |   | ense number                         | 675                                      |                               | ate signed (A                      |                           |                                    |
|                     |  |                    | terre   | k. Ich  | m                      | V   | D082                                | 0/5                                      | De                            | c. 27                              | , 2                       | 005                                |
|                     | 12   |                    | 30. Name and address of person who con<br>Hector Collison                         |   | п 23a) (Туре.<br>Coles | Primi)<br>ville                                 | Rd Sil                              | ver Spr                                  | ing,                          | MD 2                               | 090                       | 6                                  |
|                     | Sta  |                    | 31. Date filed (Month, Day, Year) DEC 3 0 2005                                    | 32. Registrar's Sign  | ature                  |   |                                     |  |                               |                                    |                           |                                    |
|                     | Registr  | વા                 | DE0 9 0 700;  | S ENDEREN SO  |                        | -   |                                     |  |                               |                                    |                           |                                    |

|   |   | 1              | For<br>State<br>Registrar   | State of  | Marylan                           |                        | rtmen<br>tificate                                |                       |                                       | ind M                 | lental Hyg                             | jiene<br>og. No.   | 5 4  | 2158   |
|---|---|----------------|---|---|-----------------------------------|------------------------|--|-----------------------|---------------------------------------|-----------------------|--|--------------------|--|--|
|   | Physicia  |                | 1. Decedent's Name (First, Middle   |   | LLEN                              |                        |  |                       |                                       |                       | 2. Date of Dea<br>Month<br>Dec         |                    | 005 <sup>Year</sup>                          | 3. Time of Death                                   |
| н   | /Medic  |                | 4a. Facility Name (If not institution   |   |                                   | -                      | •  |                       | Location o                            |                       |  |                    | nty of Death                                 | 1  |
|   |   |                | Alice Byrd Tawe   |   |                                   | land birthday)         | If Under   |                       | Field<br>If Under 2                   | 04 Hrs                | 8. Date of Birth                       |                    | merset                                       |  |
|   | uneral  <br>Director  |                | 5. Social Security Number 215–74–0326   | 6. Sex<br>1 ☐ M 2 🔀 F   | 7. Age (In yrs. I<br>82           | Yrs.                   | Months   | Days                  | Hours                                 | Min.                  | (Month, Day<br>Feb. 3                  | Year)              | Virg   |  |
| pun   | \$ (7/2)  | i  -           | Usual Residence of Decedent  10a. State 10b. County   |   |                                   | , Town or Lo           | cation   |                       |                                       |                       |  |                    | 1  | Od. Inside City Limits                             |
| Maryla  | of sho  |                |   | rset  |                                   |                        | sfield   | f                     |                                       |                       |  |                    |  | 1 ☐ Yes 2 No                                       |
| h with the  | 23a or 28e<br>st be roll  | al Director    | 10e. Street and Number<br>4524 Lawson Bar   | nes Road  |                                   |                        | 10f. Zip   |                       | 1817                                  |                       |  |                    | of What Cour                                 | ntry?  |
| 1215-0036<br>within 72 hours after death with the Maryland                    | Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-1 show amy injury or other treatmatic event, it at Neulical Eva it at man be notified at once. | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☐ Marria  3 ☑ Widowed 4 ☐ Divorced  | 12. Was Deced<br>Armed For<br>ied 1 1 Yes<br>If Yes, Give<br>Year or Da | ces?<br>2 ( <b>XKN</b> o          | 1                      | Vas Deced<br>f Yes, spec                         |                       | spanic Orig<br>n, Mexican<br>Specify: | jin? (Spe<br>, Puerto | ecify Yes or No-<br>Rican, etc.)       | 8                  | Race - Americ<br>Black, White,<br>cify: Whit | etc.   |
| Maryland 21215-0036   | ne.<br>han "natura<br>g Meulical E  | Completed      | (Specify only highe<br>Elementary/Secondary (0-12)  | t's Education<br>st grade completed)  College (1-                       |                                   |                        | lent's Usua<br>kind of woi<br>DO NOT us<br>emake | k done a<br>e retired | ution<br>Juring most                  | of worki              | ing                                    | 16b. Kind of       | Business/Ind                                 | dustry   |
| d 21  | Hygier<br>other th  | e Cor          | 6<br>17. Father's Name (First, Middle,  | Last)   |                                   | 1101((                 |  |                       | 18. Mothe                             | r's Name              | (First, Middle,                        |                    |  |  |
| aryland 2   | Mental<br>srked c   | To B           | John Thomas Er  | nis   |                                   |                        |  |                       |                                       | Alic                  | e Marsh                                | all                |  |  |
| Man<br>12 sho   | h and<br>7 Is ma<br>treum   |                | 19a. Informant's Name/Relations Iva Marshall (  |   |                                   |                        | -  |                       |                                       |                       | Rd C                                   | -                  |  |  |
| s 1 and   | item 2<br>other   |                | 20a. Method of Disposition  |   | 1 0                               | lace of Dispo          | sition (Nan                                      | ne of                 | 1                                     |                       | Date                                   |                    | n - City or To                               |  |
| Baltimore,  | ment o<br>ent: If<br>ury or   |                | 1 ∰Burial 2 ☐ Cremation<br>1 ☐ Donation 5 ☐ Other (S  |   |                                   | yridge                 | Memo   | ria1                  | Park                                  |                       | /26/05                                 | Cris               | sfield                                       | , MD   |
| Balt<br>permit.   | Depart<br>Import<br>eny inj<br>once.  |                |   | adshaw, J   | #                                 | B:                     | 06 W.  | aw &<br>Mai           | Sons<br>n St.                         | Fun<br>- Cr           | eral Ho<br>isfield                     | , MD               | 21817  |  |
|   | ysician<br>Vedical  |                | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. A L  | ach line.                         | ime                    |  |                       | enu                                   |                       | ,                                      | est,               | 4  | Approximate<br>Interval Between<br>Onset and Death |
|   | aminer  | ,              | Sequentially list conditions,   | b   |                                   |                        |  |                       |                                       |                       |  |                    |  |  |
| 4 Pag   | insit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury                                 | <   | or as a consequ                   | uence of):             |  |                       |                                       |                       |  |                    | -  |  |
| 8760, sate be exect   | obysician and<br>the burial-transit   | Ilcal Exa      | that initiated events<br>resulting in death) Last   | c. Due to (d  | or as a consequ                   | uence of):             |  |                       |                                       |                       |  |                    |  |  |
| rtificate   | ing phy<br>s as the   | Medic          | IF FEMALE:  |   |                                   |                        |  |                       |                                       |                       |  |                    |  | î  |
| ecords, P.O. Box 68760, 🛨 law requires that the death certificate be executed | by the attending pl<br>tached for use as t  | Physiclan/Med  | 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |   | nth 2 □ Fetal<br>ant at time of d | death 3                | Ectopic pr<br>Other (sp                          |                       |                                       |                       |  |                    | Date of delive<br>Month                      | ory<br>Day Year                                    |
| ecords, P.  | been signed b<br>should be deta   | by             | Part II. Other significant conditi  | ons contributing to de  | ath but not resi                  | ulting in the u        | nderlying c                                      | ause give             | on in Part I.                         |                       | 23e. Did to                            | -                  |  | ne cause of death?                                 |
| E E   | ate has<br>page 2   | Completed      |   |   |                                   |                        |  |                       |                                       |                       |  | sy<br>med?<br>2 No |  | psy findings available mpletion of cause of        |
| of Vital  | is certificate<br>director, pag   | o Be           | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No   | Hospital:   | npatient 2                        | ER/Outpatier           | <br>nt 3□ DC                                     | Othe                  |                                       |                       | n <i>(Check only oi</i><br>me 5□ Resid |                    | Other (Specifi                               | v)   |
|   | h.<br>After this<br>funeral c   | <u> </u>       | 27. Manner of Death  1 Natural 5 Pendi  | 28a. Date of  | ·                                 | 28b. Time or<br>Injury |  | 8c. injury<br>Work    |                                       |                       | 28d. Describe h                        |                    |  | ,,   |
| Division<br>or Attending  | ifter death.  Director: Al in by the fu   | Certification; | 2 Accident investi 3 Suicide 6 Could 4 Homicide determ  | not be 28e. Place   | of Injury - At ho                 | ome, farm, str<br>y)   | M<br>eet, factory                                |                       | fes 2⊡f                               | -                     | 28f. Location (S<br>City or Tow        |                    | mber or Rura                                 | ul Route Number,                                   |
| Hospitel  | within 24 hours after death.  To the Funeral Director: A completely filled in by the fu   | edical Ce      |   | ng Physician: To the<br>Examiner: On the ba<br>and mann                 | sis of examina                    |                        |  |                       |                                       |                       |  |                    |  |  |
| To the  | within<br>To the<br>compl   | Me             | 29b. Signature and title of certifie  | or .  | -                                 |                        | 290  | . License             | number                                |                       | 2                                      | 29d. Date sig      | ned (Month,                                  | Day, Year)   |
|   | ./  |                | · ( Mo  | -m  |                                   |                        |  | D 39                  | 813                                   |                       |  | Decemb             | er 23,                                       | 2005   |
|   | 5   |                | 30. Name and address of person Mike Atkins, M   |   |                                   |                        |  | sfie                  | 1d, M                                 | 1D 2                  | 21817                                  |                    |  |  |
|   | Sta<br>Regist   |                | 31. Date filed (Month, Day, Year, DEC 3 0 2   | Wan D   | egistrar's Signa                  | turo di                |  |                       |                                       |                       |  |                    |  |  |

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|--|------------------|---|--|--|---|---|--|---|
|  |                  | For State Registrar   | tate of Maryland /   | Department of H<br>Certificate of I                            |   | ntal Hygier                             | . 0 0 0  | 42159   |
| Physic   |                  | 1. Decedent's Name (First, Middle, Last)  LIZAGLHH . N  | 1. CONSTA  | NTINO  |   | Date of Death<br>Month                  | Day Year 26,2005   | 3. Time of Death 7:12 P M                             |
| /Med<br>Exami  |                  | 4a. Facility Name (If not institution, give stre<br>Good Saman tan  |  | 4b. City, Town, or   | Location of Death   |   | 4c. County of Deat   |   |
| Funera<br>Director   |                  | 5. Social Security Number 6. Sex  | 7. Age (In yrs. last b)  |  | If Under 24 Hrs. 8<br>Hours Min.                              | Date of Birth<br>(Month, Day, Yes       | 9. Birt<br>9/7   | hplace (State or Foreign untry)                       |
| /land  |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Tov   | wn or Location   | 1   |   |  | 10d. Inside City Limits                               |
| he Man<br>Ba-feh   | Director         | MD BALTIN   | rene   | PARKUILI   | 4   | 1.0-                                    | Citizen of What Co   | 1 Tyes 2 No   |
| death with the Maryland<br>rns 23a or 28a-f ehow<br>Emart be prolified at  | al Dir           | 3113 Pine wood  | Ave  | 10f. Zip Code 2 1  | 234   | log.                                    | V.S.A  |   |
| or the   | y Funeral        | 11. Marital Status 12. 1 Never Married 2 Married  | Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes Give  | 13. Was Decedent of H If Yes, specify Cuba                     | ispanic Origin? (Speci<br>in, Mexican, Puerto Ric<br>Specify: | y Yes or No-<br>can, etc.)              | 14. Race - Ame<br>Black, White<br>Specify:   |   |
| 15-UU36<br>72 hours after<br>"naturat, or its  | ted by           | .3- Widowed 4 Divorced  15. Decedent's Educati  | Year or Dates:   | a. Decedent's Usual Occup                                      |   | 16b                                     | Kind of Business/  | Uhil C<br>Industry                                    |
| within 7 iene.   | Completed        | (Specify only highest grade of Elementary/Secondary (0-12)  | College (1-4or 5+)   | (Give kind of work done of life. DO NOT use retired            | 0   | 1,                                      | sentler  | INSTRUMENT.   |
| nd Z<br>e tiled<br>al Hygir<br>f other   | Be Co            | 17. Father's Name (First, Middle, Last)   | · ·  | HODEM  | 18. Mother's Name (   | First, Middle, Maid                     | len Sumame)  |   |
| aryial<br>should b<br>nd Menti<br>marked<br>umatice  | To               | SABATING CAP  19a. Informant's Name/Relationship (Type,   |  | b. Mailing Address (Street                                     | MACIA .   |   |  | Zin Codel   |
| Md 2 lith a 27 ls  |                  | Peter ConsTANTI   | NO I   | 1503 WALLA   | ce RD. 6  | `                                       |  | 1057  |
| altimore, I  |                  | 20a. Method of Disposition  → Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)                 | oval from State  20b. Place comete  PARK   | of Disposition (Name of ery, crematory or other place)         | Dat Dat   |   | Location - City or   |   |
| Baltim pe mit Pag Deparment Imporant: I  |                  | 2). Signature of Funeral Service Licensee   | C+.00  | ,22. Name and Address<br>HARTICH MI                            | (   | LA Func                                 | RAI Ite in   | e CHD.  |
| 7 gosso  |                  | 23a. Part1. Enter the disease, or complicat   | ions that caused the death. Do   | 17527 hars   | ERD RD. 15.   | A LFS TOO                               | 21239  | Approximate   |
| Physician  |                  | shock, or heart failure. List only one of immediate Cause (Final disease or condition                       | Schemic Ca<br>Due to (or as a consequence  | rdio My  | pathy   |   | company in a decide and a decid | Interval Between<br>Onset and Death                   |
| /Medica<br>Examine   |                  | resulting in death)   | Athero Scle  | rosi's   | , ,   |   | - Proposition  |   |
| / pg isi   | ulner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence  | ∋ of):   |   |   |  |   |
| be executed cian and ourial-transit  | Examin           | that initiated events c<br>resulting in death) Last   | Due to (or as a consequence  | 9 of):   |   |   |  |   |
| <b>58/6</b> (ifficate by g physic as the bi  | edlca            | d   |  |  |   |   |  |   |
| Records, P.O. Box 68/60, The law requires that the death certificate be extended to the has been signed by the attending physician aggre? should be detached for use as the burial | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                     | If yes, outcome of pregnancy  1 Live birth 2 Fetal deat  4 Pregnant at time of death  9 Unknown            | th 3 Ectopic pregnancy<br>5 Other (specify)                    |   |   | 23d. Date of del<br>Month  | ivery<br>Day Year                                     |
| IS, P.( res that th rigned by be detact  | by Phy           | Part II. Dther significant conditions contrit   | outing to death but not resulting  | in the underlying cause giv                                    | en in Part I.   | 23e. Did tobacc                         | o use contribute to  | the cause of death?                                   |
| Cord: w require been sig   | eted             | CERNONIA, VEN   | pideméa  |  |   |   |  | obably 4 Dunknown                                     |
| VItal Records, sician: The law requires t certificate has been signs rector, page 2 should be.   | Completed        | BERD, Hyperi  | piaemea  |  |   | 24a. Was an autopsy performed 1 Yes 2 2 | ? prior to death?  | itopsy findings available completion of cause of 2 No |
| VITAL I<br>sician: Th<br>certificate<br>rector, pag  | o Be (           | 25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{D} \text{No} \)  Hos              | pital:   | Oth  | 26. Place of Death (  |   |  |   |
| on of<br>ding Phys<br>h.<br>After this<br>funeral di   | <b>—</b>         |   |  | Outpatient 3 DOA Outpatient 3 DOA 28c. Injury                  | er: 4 Nursing Home y at 28                                    | d. Describe how in                      |  | cify)   |
| DIVISION Of VIta to a Attending Physician: after death. Director: Atter this certification by the tuneral director.  | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be   | 28e. Place of Injury - At home,  |  | Yes 2 □ No 28   | f. Location (Street                     | and Number or Ru   | ural Route Number,                                    |
| DIVI   |                  | 4   Hornicide   | building, etc. (Specify)   |  |   | City or Town, St                        |  |   |
| DIVISION To the Hospitat or Attent within 24 hours after death To the Funeral Director: completely tilled in by the  | edical           | 29a. Certifier 1 Certifying Physici (Check only one)  | <ul><li>an: To the best of my knowledge</li><li>On the basis of examination a and manner stated.</li></ul> | ge, death occurred at the tir<br>ind/or investigation, in my o | ne, date and place, an<br>pinion, death occurred              | d due to the cause<br>at the time, date | e(s) and manner as<br>and place, and due   | to the cause(s)                                       |
| Tath<br>within<br>Tath   | Σ                | 29b. Signature and title of certifier   |  | 29c. Licens  | e number ( 0.539  |   | Date signed (Monti   |   |
| á  |                  | 30. Name and address of person who o mp   | pleted cause of death (Item 23a  | ) (Type, Print)  |   |   |  | - 2005  |
|  | tate             | 31. Date filled (Month, Day, Year)  | 10, 5601 LOC<br>32. Registrar's Signature  | h Raven B  | IVa , bal   | t more                                  | MD 2   | 1259  |
| Regis  |                  | DEC 3 0 2005  | Revenue &  | Carlo  |   |   |  |   |

|                  |  | -                         | For State Registrar   | State of Marylan   | id / Depa                                 | artment o  | f Health a  | nd Men                         | tal Hygie                                      |                                 | 42160  |
|------------------|--|---------------------------|---|--|---|--|---|--------------------------------|--|---------------------------------|--|
|                  | Physici<br>/Medic  |                           | 1. Decedent's Name (First, Middle, Last)  JULIA MONGO   | CAYO CAST  | ILLO                                      |  |   | , A                            | Date of Death<br>Month                         |                                 | 3. Time of Death   |
| ) .              | Examin   | er                        | 4a. Facility Name (If not institution, give s<br>FRANKLIN SQUARE  |  |   | 4b. City, Tow<br>ROSEL   | m, or Location of DALE                            | Death                          |  | 4c. County of BALTI             |  |
| 人,<br>"感         | Funeral<br>Director  |                           | 5. Social Security Number 220-92-0649 6. Sex  | 7. Age (In yrs.  | last birthday)<br>86 Yrs.                 | If Under 1 You<br>Months Da                                    | ear If Under 2<br>ays Hours                       | Min. 8. E                      | Date of Birth<br>Month, Day, Ye<br>2-16-191    | 9                               | Birthplace (State or Foreign<br>Country)<br>PHILIPINES                             |
|                  | Maryland<br>f show   | or                        | Usuel Residence of Decedent           10a. State         10b. County           MD         BAL   | TIMORE 10c. Cit  | ly, Town or Lo                            | ocation  | ROSED   | ALE                            |  |                                 | 10d. Inside City Limits 1 ☐ Yes 2 X No   |
|                  | with the   | i Director                | 10e. Street and Number 511 PATAPSCO AV  | ENUE   |   | 10f. Zip Coo   | de<br>21237                                       |                                | 10g.   | Citizen of Wha                  |  |
| 36               | within 72 hours after death with the Maryland<br>ene.<br>then "netural", or items 23e or 28e-f show<br>the Madicial Examinar must be notified at   | by Funeral                | 11. Marital Status 1 Never Married 2 Married 3 🕅 Widowed 4 Divorced   | 2. Was Decedent Ever in U<br>Armed Forces?<br>1 Yes, 2 No<br>If Yes, Give<br>Year or Dates:  |   | Was Decedent<br>If Yes, specify (<br>1 ☐ Yes 2X                | of Hispanic Orig<br>Cuban, Mexican<br>No Specity: | in? (Specify<br>Puerto Rica    | Yes or No-<br>n, etc.)                         | Black,                          | American Indian, White, etc. PHILIPINO   |
| 21215-0036       | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mertal Hygiene the Health and Mertal Hygiene from them 23s or 28s-f show them 27 is marked other then "netural", or Itams 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at | Completed                 | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | cation<br>completed)<br>College (1-4or 5+)   | (Give                                     | dent's Usual Oo<br>kind of work do<br>DO NOT use re<br>HOMEMAI | one during most<br>etired)                        | of working                     | 16b  | OWN H                           |  |
|                  | 2 should be filed within 7 and Mental Hygiene. Fis marked other then "raumatic event, the Mad  | To Be Co                  | 17. Father's Name (First, Middle, Last) MATIAS  | MONGCAYO   | 1   |  |   | 's Name <i>(Fir.</i><br>)RTUNA | st, Middle, Maid                               | den Sumame)<br>(MAI             | LUM)   |
|                  | 1 and 2 shou<br>Health and M<br>Ism 27 is mai  |                           | 19a. Informant's Name/Relationship (Type<br>MARCELA SOUTHERLA   |  |   |  | reet and Numbe                                    |                                | ute Number, Ci                                 |                                 | ate, <i>Zip Cod</i> e)<br>21237  |
| Baltimore,       | Page<br>nent c<br>nt: if<br>rry or   |                           | 20a. Method of Disposition  1 Burial 2 Cremation 3 A 4 Donation 5 Other (Specify)   | amoval from State  | Place of Dispo<br>cemetery, crei<br>ANAUA | osition (Name of<br>matory or other<br>N                       | place)  | Date 1/05/                     |  |                                 | ty or Town, State TANCAS PHILIPPINES   |
| Balt             | permit. Departrimporte any inju  |                           | 21. Signature Financial rvice cense   | 96   |   |  | ddress of Facility                                |                                |  | ALE FUN<br>ALE, MD              | ERAL HOME<br>21237   |
| 8760,            | death certificate be executed  e attending physicien and for use as the burial-transit   | dical Examiner            | 23a. Pant1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consecutive to (or a))). | quence of):                               | a AL   |   | is6AS                          |  |                                 | Interval Between Onset and Death   |
| Box 6            | that the death certific<br>ted by the attending p<br>detached for use as   | Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown  | 3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o   | al death 3                                | □Ectopic pregn<br>□ Other (specif                              |   |                                |  | 23d. Date of Month              |  |
| rds, P.O.        | w requires that the<br>been signed by th<br>should be detache  | ed by Ph                  | Part II. Other significant conditions con   | etributing to death but not res  | sulting in the u                          | inderlying caus  | e given in Part I.                                |                                | 23e. Did tobac                                 | _                               | ute to the cause of death?   |
| of Vital Records | The law<br>ete hes b<br>page as  | Complet                   |   |  |   |  |   |                                | 24a. Was an<br>autopsy<br>performed<br>1 Yes 2 | t2 dea                          | re autopsy findings available<br>or to completion of cause of<br>hth?<br>Yes 2□ No |
| Vita             | ysician: Th<br>is certificete<br>director, pag   | Be                        | 25. Was case referred to medical examiner?  | lospital:  |   |  | Other   |                                | eck only one                                   |                                 |  |
| on of            | ding Phys<br>h.<br>After this<br>funeral di  | tion: To                  | 1 Yes 2 No  27 Manner of D ath  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury                    |  | Other: 4 Nui                                      | 28d.                           | 5 Residence Describe how i                     |                                 |  |
| Division         | al or Attending<br>s after death.<br>il Director: After<br>id in by the fune   | Certification:            | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Special   | iome, farm, st                            | reet, factory, of  | fice  | 28f. I                         | Location (Stree<br>City or Town, S             | t and Number<br>(tate)          | or Rural Route Number,   |
|                  | To the Hospital or Attan<br>within 24 hours after deat<br>To the Funeral Director:<br>completely filled in by the  | edicai                    | 29a. Certifier 12 Certifying Physics (Check only one) 12 Medical Examination  | sician: To the best of my kniner: On the basis of examinand manner stated.   | owledge, deat<br>ation and/or in          | th occurred at the   | he time, date and<br>my opinion, deat             | d place, and o                 | due to the caus<br>t the time, date            | e(s) and mann<br>and place, and | er as stated.<br>d due to the cause(s)   |
|                  | To the within 2 To the complete  | M                         | 29b. Signature and vitle of certifier   | 1D   |   |  | cense number                                      | 946-                           |  |                                 | Month, Day, Year)<br>12 , 28, 2005   |
|                  | ix   |                           | 30. Name and address of person who co   | mpleted cause of death (Ite  | 1 0                                       |  |   |                                | 3ALTIM.  |                                 |  |
| 4                | Sta<br>Regist  |                           | 31. Date filed (Month. Day, Year) DEC 3 0 200   | 32/Registrar's Sign  | ature                                     | will .   |   | T                              |  |                                 |  |

|  |                        | 1 | For<br>State<br>Registrar  |                 | State of  |                           |                      | d / Depa                      |   | t of H                             | lealth a                  | and M                    | lental H                  |                        | ie<br>O O | 5 L                        | 21               | 61                                     |
|--|------------------------|---|--|-----------------|---|---------------------------|----------------------|-------------------------------|---|------------------------------------|---------------------------|--------------------------|---------------------------|------------------------|-----------|----------------------------|------------------|--|
| Phy  | sician                 |   | . Decedent's Name (First, Middle   | , Last)         | 1   |                           |                      |                               |   |                                    |                           |                          | 2. Date of Month          |                        | ay        | Year                       | 3. Tir           | ne of Death                            |
| /Me  | edical                 |   | Elfriede Cosgrove  |                 |   |                           |                      |                               | T                                       |                                    |                           |                          | 12                        |                        | 9         | 2005                       | 4                | 38 P M                                 |
| Exa  | miner                  | 1 | a. Fecility Name (If not institution<br>Greater Laure) He.   |                 |   | n <i>ber)</i>             |                      |                               | 4b. City,<br>Laur                       |                                    | Location                  | of Death                 |                           | 4                      |           | ty of Death                |                  |  |
| - T T.   |                        | 5 | . Social Security Number   | 6. Sex          |   | 7. Age (II                | n vrs. la            | st birthday)                  |   | -                                  | If Under                  | 24 Hrs.                  | 8. Date of I              | Birth                  |           | e Geor                     |                  | ate or Foreign                         |
| Fune<br>Direct   |                        |   | 509-40-4016  |                 | M 2∭F   | 8:                        |                      | Yrs.                          | Months                                  | Days                               | Hours                     | Min.                     | (Month,<br>2-19-1         | Day, Yea               | ır)       | Germa                      |                  | ate or Foreign                         |
| land<br>ow   |                        | - | Oa. State 10b. County  |                 |   | 10                        | Dc. City             | Town or Lo                    | cation                                  |                                    | ·                         |                          |                           |                        |           | 1                          | 0d. Insi         | de City Limits                         |
| the Marylan<br>r 28a-f show  | Ď                      | М | aryland Prince   | Geor            | ge  |                           | La                   | urel                          |   |                                    |                           |                          |                           |                        |           |                            | 1 📉              | Yes 2 □ No                             |
| 5-0036 72 hours after death with the Maryland nature!; or Itame 23a or 28s-1 show the Earling of the collection of the c | i Director             | 1 | Oe. Street and Number<br>8123 Gavin Street   |                 |   |                           |                      |                               | 10f. Zip                                | Code<br>784                        |                           |                          |                           | -                      |           | What Coun                  | •                | 3                                      |
| deatt  | Funeral                | 1 | 1. Marital Status  |                 | 12. Was Dece<br>Armed For                                   | dent Eve                  | r in U.S             | 3. 13.                        | Was Deced                               | lent of Hi                         | ispanic Ori               | igin? (Spe               | ecify Yes or i            | No-                    |           | ce - Americ                |                  | ın,                                    |
| 036<br>ours after  | by Fu                  |   | 1 Never Married 2 Marr<br>3 Widowed 4 🕅 Divorced   | i <b>e</b> d    | 1 [] Yes<br>If Yes, Give<br>Year or Da                      | 2 <b>∏</b> No             |                      |                               | 1 ☐ Yes                                 |                                    | Specify:                  |                          | nican, etc.)              |                        |           | ack, White,<br>Mr. Whit    |                  |  |
|  | Completed              |   | 15. Deceden (Specify only highest Elementary/Secondary (0-12)  | 's Edu          | cation<br>completed)<br>College (1-                         | 40r 5±)                   |                      | 16a. Deced<br>(Give<br>life.  | dent's Usua<br>kind of wor<br>DO NOT us | l Occupa<br>k done d<br>se retired | ation<br>during mos       | t of work                | ng                        | 16b.                   | Kind of E | 3usiness/Ind               | dustry           |  |
| nd 2121  se filed within al Hygiene. I other then '  | ĕ                      |   | 12   |                 | College (1  |                           |                      | Wai                           | tress                                   |                                    |                           |                          |                           | Re                     | staur     | ant                        |                  |  |
| be file<br>tal Hy<br>doth  | Be                     | 1 | 7. Father's Name (First, Middle,   | Last)           |   |                           |                      |                               |   |                                    | 18. Mothe                 | er's Name                | (First, Midd              | lle, Maide             | n Suma    | me)                        |                  |  |
| Tarylan 2 should be and Mental 10 marked aumatic ev  | ဦ                      |   | Rudolf Rietzler  |                 |   |                           |                      |                               |   |                                    | Ma                        | arie L                   | indeman                   | n                      |           |                            |                  |  |
| Maryland  1d 2 should be file  1st and Mental Hy  27 Is marked oth  1st aumatic event  | 15                     | 1 | 19a. Informant's Name/Retations  | nip (Ty         | pe, Print)  |                           |                      |                               |   |                                    |                           |                          | l Route Nun               |                        |           |                            | Code)            |  |
| e, Not and tealth im 27  |                        |   | Joachim Rietzler/  | son             |   |                           | 20h Bl               | 8123 G<br>ace of Dispo        |   |                                    | , New                     |                          | llton,                    | -                      |           |                            |                  |  |
| Baltimore, Mipermit. Pages 1 and 2 Department of Health a Important: If item 27 item 2 |                        |   | 0a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)  | 3 □R<br>oecify) | emoval from S   |                           | CO                   | metery, crer<br>ional (       | natory or o                             | ther plac                          | e) 1                      | 2-23-                    |                           |                        |           | - City or To<br>rch, Vi    |                  |  |
| Balt<br>permit.<br>Depart<br>Import  | Suce                   |   | 21. Signature of Funeral Service   | License         | Malle   | _                         |                      |                               | 2. Name an                              |                                    |                           |                          | eck Fun<br>urel, M        |                        |           | 707                        |                  |  |
| Physicial Medic Examin harding and harding harding and physician and phy | al Examiner            |   | shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Lause (Disease or injury hat initiated events esulting in death) Last |                 | Hepato<br>Due to (d   | or as a co                | onseque              | ence of):                     | oma                                     |                                    |                           |                          |                           |                        |           |                            | Onset 3 mor      | imate<br>I Between<br>and Death<br>ths |
| I Records, P.O. Box 68  The law requires that the death certifical ate hes been signed by the attending phy page 2 should be detached for use as the   |                        |   | F FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 ☒ No<br>9 □ Unknown   | 2               | 3c. If yes, outc<br>1 □ Live bin<br>4 □ Pregna<br>9 □ Unkno | nth 2 ☐<br>ant at time    | Fetal                | death 3                       | Ectopic pro                             |                                    |                           |                          |                           |                        |           | ate of delive              | ry<br>Day        | Year                                   |
| dS, P<br>uires that<br>signed to<br>d be detail  | d by P                 | P | art II. Other significant condition Hepatitis C, Ascit   |                 |   |                           | ot resul             | ting in the ur                | nderlying ca                            | use give                           | en in Part I.             |                          |                           |                        | use con   | tribute to th              |                  | of death?                              |
| Records, he law requires to the been signed as should be ended to be ended by the law to | Completed by           |   |  |                 |   |                           |                      |                               |   |                                    |                           |                          | 24a. Wt                   | is an                  | 24b.      | prior to con               | sy find          | ngs available of cause of              |
| Vital F ilcian: Th certificate   | ខ                      |   |  |                 |   |                           |                      |                               |   |                                    |                           |                          |                           | fórmed?<br>2 💢 N       | 0         | death?                     | 2 🗆 No           |  |
| Vital eician: T certificate irector, pa  | Be                     | 2 | 25. Was case referred to medical examiner?   | Н               | ospital:  |                           |                      |                               |   | Othe                               |                           |                          | Check only                |                        |           |                            |                  |  |
| Vision of Vita Attending Physician: r death. sctor: After this certific by the funeral director.   | 5.                     |   | 1 ☐ Yes 2 ☒ No<br>7. Manner of Death   | -               | 28a. Date o   | patient<br>f Injury       | -                    | P/Outpatien<br>28b. Time of   |   | ^                                  | 4 💢 140                   |                          | ne 5 Re                   |                        |           |                            | )                |  |
| ion of the star of tuneral   | 할                      |   | 1 Natural 5 Pendin<br>2 Accident investig  |                 | (Month  | i, Day Ye                 | ear)                 | Injury                        | М                                       | 3c. tnjury<br>Work                 | :?<br>/es 2 □ i           |                          |                           |                        | .,        |                            |                  |  |
| Division of to Attending Phy after death. Director: After this in by the funeral d   | ertifica               |   | 3 Suicide 6 Could r<br>4 Homicide determ   | ot be<br>ned    | 28e. Płace o<br>buildin                                     | of Injury -<br>g, etc. (S | - At hon<br>Specify) | ne, farm, str                 | eet, factory                            | office                             |                           | 2                        | 8f. Location<br>City or T | (Street a              | ind Numi  | ber or Rural               | Route            | Vum <i>ber</i> ,                       |
| Division of Vital Remains to the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate the complaintly filled in by the funeral director, page   | Medical Certification: | 1 | 29a. Certifier 1 🗓 Certifyin (Check only one)  | Phys            | ician: To the later: On the baland mann                     | SIS Of 9X2                | amınatı              | tedge, death<br>on and/or inv | occurred a<br>restigation,              | at the tim                         | e, date an<br>pinion, dea | d ptace, a<br>th occurre | ind due to the            | e cause(<br>e, date ar | s) and m  | anner as sta<br>and due to | ated.<br>the cau | se(s)                                  |
| To the within To the comple  | ₩                      | 2 |  | W.              |   |                           |                      | 20                            | 290                                     | License                            | number<br>211             | 292                      | <del>-</del>              | 29d. D                 | ate signe | 28/                        | 0 ay, Yea        | ar)                                    |
| 5  |                        | 3 | O. Name and address of person ABDUL NAYE   | The con         | mplet cause   | of death                  | (Item :              | 23a) (Type,                   | Print) ME                               | FAD                                | E Ro.                     | AD, S                    | BUTT                      | = 100                  | 1,21-     | URE                        | 2 M              | D2072                                  |
| A STATE OF THE STA | State<br>istrar        | 3 | 1. Date filed (Month, Day, Year)   |                 | 32. Re  | oistrar's                 | Signatu              | re                            | e portion                               |                                    |                           |                          |                           |                        |           |                            |                  |  |

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a PI perMD, 6850, 12-30-05 TI State of Maryland' Department of Health and Mental Hygiene 055 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death William **Physician** Month WAYNE 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUNDER JE GRACE

If Under 24 Hrs. 8. Da HARford 5. Social Security Number Age (In yrs. last birthday) 9/Birthplace (State or Foreign Country) **Funeral** Date of Birth (Month, Day, Year) Months Hours 1**∑**M 2□F Director Yrs 213-46-0285 Maryland July 29,1946 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Itams 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location iral', or Itams 23a or 28a-f show Exaculter must be notified at 10d. Inside City Limits Director Maryland Harford Aberdeen 1 Yes 3 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21001 82 Norman Avenue USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ∐ Yes 2 M∑No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Technician Local Government item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Franklin Cox Clara Nevada Tibbs 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda Lou Cox - Wife nt of Health a: If item 27 la 82 Norman Avenue, Aberdeen, Maryland 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Bel Air Mem. Gardens 12/28/2005 Fel Air, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Enysician /Medical Due to (or as a consequence of): **Examiner** 1001 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Respiratory Failure Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. þ funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, CORONARY ARTERY 1 Ves 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check on one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of partifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D40922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

DEC 3 0 2005

32. Registrar's Signature

|            |  |               | 1 - For<br>Stata<br>Ragistrar  | State of   | Marylan                    | -                      | artment of F                               |                          | ind Mental H                                 | ygiene                | 05                       | 42163   |
|------------|--|---------------|--|--|----------------------------|------------------------|--|--------------------------|--|-----------------------|--------------------------|---|
|            |  |               | 1. Decedent's Name (First, Middle, L   | ast)   |                            |                        |  |                          | 2. Date of E                                 | Death                 |                          | 3. Time of Death                              |
|            | Physic<br>/Medi  |               | Michael John   | Campbell   |                            |                        |  |                          | Decemb                                       | er 26                 | 2005                     | 14:05 M                                       |
|            | Exami  |               | 4a. Facility Name (If not institution, gr  |  | ber)                       |                        | 4b. City, Town, or                         | r Location of            |  |                       | County of Deat           |   |
|            |  |               | 1112 F Vangu   | ard Way  |                            |                        | Bel A                                      | ir                       |  |                       | Harfo                    | ord   |
|            | Funeral  |               | 5. Social Security Number 6.   | Sex 7  | . Age (In yrs.             | last birthday)         | If Under 1 Year                            | If Under 2               |  | Birth                 | 9. Birt                  | holace (State or Foreign                      |
|            | Director   |               | 014-60-9197  | 12XM 2□F   | 40                         | Yrs.                   | Months Days                                | Hours                    | Min. (Month, L<br>NOV • 1                    | Day, Year)<br>.5, 190 | Co                       | ssachusetts                                   |
|            | D D  |               | Usual Residence of Decedent  |  |                            |                        |  |                          | 11001  |                       | OD Had                   | bachusetts                                    |
|            | nylan<br>how   |               | 10a. State 10b. County   |  | 10c. Cit                   | y, Town or Lo          | ocation                                    |                          |  |                       |                          | 10d. Inside City Limits                       |
|            | Ma<br>iffie  | Director      | Maryland Harfo   | rd   |                            | Bel A                  | ir   |                          |  |                       |                          | 1 ☐ Yes 2 📉 No                                |
|            | n 28   | ire           | 10e. Street and Number   |  |                            |                        | 10f. Zip Code                              |                          |  | 10g. Citize           | en of What Co            | untry?  |
|            | h wil  | <u>=</u>      | 1112 F Vangua  | rd Wav   |                            |                        | 21   | 014                      |  |                       | USA                      |   |
|            | deat<br>ms   | Funeral       | 11. Marital Status   | 12. Was Deced  | lent Ever in U.            | S. 13.                 |  |                          | in? (Specify Yes or N<br>Puerto Rican, etc.) | 10- 14                | 1. Race - Ame            | rican Indian,                                 |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumstic event, Ite Medical Examinar must be notified at | by            | 1 XNever Married 2  Married<br>3  Widowed 4  Divorced                              | Armed Ford<br>1 Yes 2<br>If Yes, Give<br>Year or Dat | No                         |                        | If Yes, specify Cuba<br>1 ☐ Yes 2 🙀 No     | Specity:                 | Puerto Rican, etc.)                          | 1 _                   | Black, White<br>Specify: | white   |
| 9          | 2 ho   | Completed     | 15. Decedent's E   | ducation   |                            | 16a. Dece              | dent's Usual Occup                         | ation                    |  | 16b. Kind             | d of Business/I          |   |
| 215        | hin 7  | ple           | (Specify only highest girls<br>Elementary/Secondary (0-12)                         | 2 de completed) College (1-4                         | 4or 5+\                    | life.                  | kind of work done of<br>DO NOT use retired | during most (<br>f)      | of working                                   |                       |                          |   |
| 21         | d with   | E O           | 12   | College (1-  | 401 347                    | Hair                   | Stylist                                    |                          |  | Hair                  | Salon                    | ,   |
| 0          | othe   | Be            | 17. Father's Name (First, Middle, Las  | t)   |                            |                        |  | 18. Mother               | 's Name (First, Middl                        |                       |                          |   |
| ar         | lid be lenta   | To B          | Joseph David Car   | mpbell   |                            |                        |  | Jar                      | nice Ann C                                   | apello                | )                        |   |
| Maryland   | 12 should be filed within on and Mental Hygiene. Fis marked other then "reumetic event, the Mental Heads."   | -             | 19a. Informant's Name/Relationship   |  |                            | 19b. Mailir            | ng Address (Street a                       |                          | or Rural Route Num                           | de                    |                          | in Code)                                      |
| N          | od 2<br>Ith all<br>27 is<br>110.   |               | Joseph Campbell  | / Father   | <u>-</u>                   |                        |  |                          | Forest Hi                                    |                       |                          |   |
| ē,         | is 1 and 2<br>of Health<br>item 27 i   |               | 20a. Method of Disposition   | -  | 20b. P                     | lace of Dispo          | sition (Name of                            | 1                        | Date   | _                     | ation - City or 1        |   |
| <u></u>    | Pages<br>nent of H<br>ant: If ite  | 100           | 1 X Burial 2 ☐ Cremation 3 (   |  | tate [                     |                        | natory or other plac                       | -                        |  |                       |                          |   |
| Baltimore, | permit. Pages<br>Department of<br>Importent: If i<br>any injury or o   | 9             | ' 4 □ Donation 5 □ Other (Spec   |  | Dar.                       | Lingto:                | n Cemeter                                  | y   12                   | 2/30/2005                                    | Darli                 | ngton,                   | Maryland                                      |
| Ba         | permit. Departri Importe any inju  |               | 21. Signature of Funeral Service Lice  | 200  |                            | N                      | ICCOmas Fi                                 | is of Facility<br>ineral | _Home, P.                                    | Α.                    |                          |   |
|            |  |               | Juste U.   | wight  |                            |                        | 131/Cokes                                  | sbury                    | Road, Abi                                    | ngdon,                | Maryl                    |   |
| п          |  | ·             | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only        | nplications that cau<br>rone cause on ear            | used the death<br>ch line. | n. Do not ent          | er the mode of dying                       | g, such as ca            | ardiac or respiratory                        | arrest,               |                          | Approximate<br>Interval Between               |
|            | Physician  |               | Immediate Cause (Final disease or condition  |  | MPLI                       | CATIO                  | NS OF                                      | A.                       | J. 15.5.                                     |                       |                          | Onset and Death                               |
|            | /Medical   |               | resulting in death)  |  | r as a consequ             |                        |  |                          |  |                       |                          |   |
|            | Examiner   |               | Conventially list conditions   | b  |                            |                        |  |                          |  |                       |                          |   |
|            | B = 5  | Je            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying |  | r as a consequ             | uence of):             |  |                          |  |                       |                          |   |
|            | cate be executed<br>physician and<br>the burial-transit  | Examine       | Cause Usease or Injury that initiated events                                       | C.   |                            |                        |  |                          |  |                       |                          |   |
| oʻ         | exector and and artical-tu   |               | resulting in death) Last   |  | r as a consequ             | uence of);             |  |                          |  |                       |                          |   |
| 8760,      | sicia<br>vsicia<br>e bu  | dical         |  | d  |                            |                        |  |                          |  |                       |                          |   |
| 9          | death certificate be executed<br>e attending physician and<br>od for use as the burial-transit   | edi           |  |  |                            |                        |  |                          |  |                       |                          |   |
| Вох        | leath certific<br>attending p<br>i for use as  | Physician/Med | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outco                                   | ome of pregna              |                        |  |                          |  | 230                   | d. Date of deliv         | rerv  |
| m          | death<br>a atte  | cia           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   |  | h 2 Fetal                  |                        | Ectopic pregnancy Other (specify)          |                          |  |                       | Month                    | Day Year                                      |
| o.         | at the de<br>by the  | ıysi          | 9 Unknown  | 9□ Unknow  | /n                         |                        |  |                          |  |                       |                          |   |
| Δ.         | \$ 8 8   |               | Part II. Other significant conditions  | contributing to dea                                  | th but not resu            | ulting in the ur       | nderlying cause give                       | n in Part I.             | 23e. Did                                     | tobacco use           | contribute to            | the cause of death?                           |
| ds         | sign<br>d be   | d by          |  |  |                            | _                      | , ,  |                          |  | Yes 2 1               |                          | bably 4 Munknown                              |
| Records,   | w requir<br>been s<br>should   | ompleted      |  |  |                            |                        |  |                          | -  |                       |                          |   |
| ec         | 2 5 8  | ldu           |  |  |                            |                        |  |                          | 24a. Was                                     | psy                   | prior to co              | opsy findings available ompletion of cause of |
|            | Th<br>ate<br>pag   | Co            |  |  |                            |                        |  |                          | perf<br>1 ☐ Yes                              | ormed?                | death?<br>1 ☐ Yes        | 2 No  |
| of Vital   | Phyeicien: Th<br>this certificate<br>ral director, pag   | Be            | 25. Was case referred to medical examiner?   |  |                            |                        |  | 26. Place o              | f Death (Check only                          | one)                  |                          |   |
| 1          | y is   | 2             | Yes 2 No   | Hospital: 1   Inp                                    | oatient 2 🗆 I              | ER/Outpatien           | t 3 DOA Othe                               | r. 4 🗆 Nurs              | ing Home 5 K Res                             | idence 6 [            | Other (Speci             | fy)   |
| 0          | ng Pl  | ou:           | 27. Manner of Death  1 Natural 5 Pending   | 28a. Date of (Month.                                 | Injury<br>Day Year)        | 28b. Time of<br>Injury | 28c. Injury<br>Work                        | at                       | 28d. Describe                                | how injury o          | ccurred                  |   |
| <u>Ö</u>   | Attending<br>r death.<br>sctor: After  | atic          | 2 Accident investigation   |  | , , , ,                    | , y                    |  | es 2 □ No                | 0  |                       |                          |   |
| Division   | l or Attence<br>after death<br>Director:<br>in by the  | Certificati   | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined                               | 286. Place of  | f Injury - At ho           | me, farm, stre         | eet, factory, office                       |                          |  |                       | Number or Run            | al Route Number,                              |
|            | el or A<br>s after<br>il Dire  | ert           | 4 El Homolog   | buildirig  | , etc. (Specify            | )                      |  |                          | City or 10                                   | wn, State)            |                          |   |
|            | To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral  |               | 29a. Certifier 1 ☐ Cartifying Pi   | nysician: To the b                                   | est of my know             | viedge, death          | occurred at the time                       | e, date and              | place, and due to the                        | cause(s) an           | d manner as s            | stated.                                       |
|            | e Ho<br>24 /<br>e Fu<br>letely   | edical        | (Check only one) 2 Madical Exa   | miner: On the bas<br>and manne                       | is of examinat             | ion and/or inv         | estigation, in my op                       | inion, death             | occurred at the time,                        | date and pla          | ace, and due t           | o the cause(s)                                |
|            | omp  | Me            | 29b. Signature and title of certifier  | N  |                            |                        | 29c. License                               | number                   |  | 29d. Date s           | igned (Month,            | Day, Year)                                    |
|            | FSFO   |               | 9 anninh   | Kal-   | 1-                         | 61.41                  | 6  | 218                      | Ta   |                       | _                        | -   |
|            | 10   |               | TOUCOLA  | 10   | .~~                        | Mai                    |  | 218                      |  | 966                   | ims o                    | (28 2002                                      |
|            | Ψ  |               | 30. Name and address of person who   | completed cause                                      | of death (Item             | 23a) (Type, I          |  |                          | <b>-</b> .                                   |                       |                          |   |
|            |  |               | 7-5- 1143th 1  | 1-0.   | 2336                       | 401                    | 1 POP                                      | <del>-</del> 4           | IMON   | JM                    | MD                       | 21593   |
|            | Sta  |               | 31. Date filed (Month, Day, Year)  |  | jistrar's Signat           | ure                    |  | ,                        |  |                       |                          |   |
|            | Registr  | - 1           | DEC 3 0 2  | 005  | 49                         | 2,                     | 2.00                                       |                          |  |                       |                          |   |
| DH         | MH 17 Rev 1/2  | 001           |  | J. Land  | less d                     | S. Figure              |  |                          |  |                       |                          |   |
|            |  |               |  |  | (                          | ORIGINA                | \L.  |                          |  |                       |                          |   |

|                          |   |                | For<br>State<br>Registrar  | State of N                                     | /larylan              |                              | artment of H   |                            |                                    |                             | ene 05                      | 42164   |
|--------------------------|---|----------------|--|--|-----------------------|------------------------------|--|----------------------------|------------------------------------|-----------------------------|-----------------------------|---|
|                          | -   | 1              | 1. Decedent's Name (First, Middle,   | Last)  |                       |                              |  |                            |                                    | ate of Death                | 1                           | 3. Time of Death                                    |
|                          | Physici<br>/Medic   |                | Larry W. Cowgo   | ar   |                       |                              |  |                            |                                    | cember                      |                             | LA LA   |
| ).                       | Examin  |                | 4a. Facility Name (If not institution,   | give street and numbe                          | r)                    |                              | 4b. City, Town, or   | Location of                | of Death                           |                             | 4c. County of De            | ath   |
|                          |   | 4              | 1010 Shoreland D   |  |                       |                              | Glen Bur   |                            | 04.0                               |                             | Anne Arı                    |   |
| ۸.                       | Funeral   |                | ,  | 5. Sex 7. A<br>1 🔀 M 2 🗆 F                     | Age (In yrs.<br>60    | last birthday)<br>Yrs.       | If Under 1 Year<br>Months Days   | If Under<br>Hours          | Min. (A                            | ate of Birth<br>Jonth, Day, | Year)                       | irthplace (State or Foreign<br>Country)             |
|                          | Director  |                | 233-70-5188 Usual Residence of Decedent  |  |                       |                              |  |                            | Apr                                | CIL 16                      | , 1945 Ma                   | ryland  |
|                          | yland   |                | 10a. State 10b. County   |  | 10c. Cit              | y, Town or Lo                | cation   |                            |                                    |                             |                             | 10d. Inside City Limits                             |
|                          | e-fel   | ctor           | Maryland Anne A  | runde1   | Gle                   | n Burn:                      | ie   |                            |                                    |                             |                             | 1 ☐ Yes 2 X No                                      |
|                          | or 28   | Director       | 10e. Street and Number   |  |                       |                              | 10f. Zip Code  |                            |                                    | 10                          | g. Citizen of What (        | Country?  |
|                          | 23a   |                | 1010 Shoreland D   | rive   |                       |                              | 21060  |                            |                                    | Ur                          | nited Stat                  | tes   |
|                          | teme  | Funeral        | 11. Marital Status   | 12. Was Deceder<br>Armed Forces                | s?                    | .S. 13. \                    | Vas Decedent of H<br>f Yes, specify Cuba   | ispanic Ori<br>in, Mexican | gin? (Specify )<br>i, Puerto Ricar | res or No-<br>n, etc.)      | 14. Race - Arr<br>Black, Wh |   |
| 36                       | within 72 hours affer death with the Maryland<br>ane.<br>then 'naturaf', or iteme 23e or 28e-f ehow<br>the Mudical Exercites translate notified at  | by F           | 1 ☐ Never Married 2 🔀 Marner 3 ☐ Widowed 4 ☐ Divorced  | d 1 ☐ Yes 2 ∑<br>If Yes, Give<br>Year or Dates |                       |                              | l ☐ Yes 21 No  | Specify:                   |                                    |                             | Specify: W                  | hite  |
| 9                        | hour  |                | 15. Decedent's   |  | ··                    | 16a Decer                    | lent's Usual Occupa  | ation                      | -                                  | 1                           | 6b. Kind of Busines         | s/Industry  |
| 5                        | n "na   | piet           | (Specify only highest  | grade completed)                               |                       | (Give                        | kind of work done of   | durina most                | t of working                       | '                           | OD. KING OF DUSINGS         | amoustry  |
| 212                      | jiene<br>r the  | Completed      | Elementary/Secondary (0-12)  | Cottege (1-4o                                  | r 5+)                 | Super                        | visor  |                            |                                    | M                           | lanufactui                  | ing   |
| b                        | e filed<br>al Hygi<br>other<br>vent,  | Bec            | 17. Father's Name (First, Middle, La   | ist)   |                       |                              |  | 18. Mothe                  | er's Name (Firs                    | t, Middle, M                | laiden Sumame)              |   |
| /lai                     | 2 should be<br>and Mental<br>is marked o  | 2              | Denzel Cowgar  |  |                       |                              |  | Gene                       | evieve                             | Sears                       |                             |   |
| Maryland 21215-0036      | s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene it is marked other then "natural", or iteme 23a or 28e-1 show other traumatic event, its Medical Execution invalue notified at |                | 19a. Informant's Name/Relationship   | ) (Туре, Print)                                |                       | 19b. Mailin                  | g Address (Street a  | and Numbe                  | er or Rural Rou                    | rte Number,                 | City or Town, State,        | Zip Code)   |
| ≥,                       | and<br>lealth<br>m 27<br>her tr   |                | Bonnie Cowgar /  | wife   | 001 0                 | 1010                         | Shoreland  | Driv                       | re, Gle                            |                             | nie, MD 21                  |   |
| Ore                      | ges 1<br>f of H<br>H ite<br>or ot   |                | 20a. Method of Disposition 1   → Burial 2   → Cremation 3  | ☐Removal from Stat                             |                       |                              | sition (Name of<br>natory or other place   |                            | ec. 31                             | ,                           | Oc. Location - City of      |   |
| Baltimore,               | t. Pa<br>rfmen<br>rtent:<br>njury   |                | 4 Donation 5 Other (Spe  |  | GLe                   |                              | n Mem. Pa  | 1                          | 2005                               | G                           | Elen Burni                  | e, Maryland   |
| Bal                      | permit. Pages 1 and 2 s<br>Department of Health ar<br>importent: If item 27 is<br>any injury or other trau  |                | 21. Signature of Experal Service Lie   | ensee  |                       | ]                            | . Name and Addres<br>Kirkley-R<br>421 Crain  | uddic                      | k Fune:                            |                             | me, P.A.<br>Burnie, N       | 1D 21061  |
|                          |   |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or   | omplications that cause on each                | ed the death<br>line. | h. Do not ente               | ar the mode of dyin  | g, such as                 | cardiac or resp                    | oratory arres               | st,                         | Approximate<br>Interval Between                     |
|                          | Pnysician   | 0.3            | Immediate Cause (Final disease or condition  |  | ed                    | es lyl                       | Cola   | Ca                         | rea/                               | -                           |                             | Onset and Death                                     |
|                          | /Medical<br>Examiner  |                | resulting in death)  | Due to (or a                                   | s a conseq            | uence of):                   |  |                            |                                    |                             |                             |   |
|                          | 1. 3. 1. 1  | <u>L</u>       | Sequentially list conditions, if any, leading to immediate   | bb. Due to (or a                               | 15 2 CODERO           | uance of):                   |  |                            |                                    |                             |                             |   |
|                          | ted<br>nsif   | nine           | cause. Enter Underlying Cause (Disease or injury   | 20010 (01 a                                    | is a consequ          | derica or,                   |  |                            |                                    |                             |                             |   |
|                          | al-fra  | Examine        | that initiated events<br>resulting in death) Last  | c<br>Due to (or a                              | is a consequ          | uence of):                   |  |                            |                                    |                             |                             |   |
| 8760,                    | cate be executed<br>physician end<br>the burial-fransif   | dical          | (  | d  |                       |                              |  |                            |                                    |                             |                             |   |
| .89                      | ifficati<br>g phy<br>as fhe   | edic           |  | · ·  |                       |                              |  |                            |                                    |                             |                             |   |
| Вох                      | thef the death certific<br>ed by the affending p<br>defached for use as i   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcom                            |                       |                              | lc-+i  |                            |                                    |                             | 23d. Date of de             | elivery   |
|                          | death   | icia           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1☐Live birth<br>4☐Pregnant                     | at time of d          |                              | Ectopic pregnancy<br>Other (specify)   |                            |                                    |                             | Month                       | Day Year  |
| P.O.                     | thef the<br>ed by th<br>defache   | hys            | 9 Unknown  | 9□ Unknown                                     |                       |                              |  |                            |                                    |                             |                             |   |
| Ś                        | res the<br>signed<br>be del   | by F           | Part II. Other significant condition   | s contributing to death                        | but not resi          | ulting in the ur             | derlying cause give  | en in Part I.              | . 2                                | 3e. Did toba                |                             | to the cause of death?                              |
| ord                      | The law requires<br>ife has been signi<br>bege 2 should be  | ted            |  |  |                       |                              |  |                            |                                    | 1 🗌 Yes                     | s 2 GMNo 3 □ F              | Probably 4 Unknown                                  |
| ec                       | iaw ias be  | Completed      |  |  |                       |                              |  |                            | 2                                  | 4a. Was an autopsy          | prior to                    | utopsy findings available<br>completion of cause of |
| =                        | (Q La   | S              |  |  |                       |                              |  |                            | 1                                  | perform                     | ed? death?<br>☑ No 1 ☐ Ye   |   |
| Division of Vital Record | Physicien: Th<br>this certificate<br>ral director, peg  | Be             | 25. Was case referred to medicat examiner?   | Hospital:                                      |                       |                              | 0.4  |                            | of Death (Che                      | ck only one                 | )                           |   |
| of                       | Phys<br>this<br>al dir  | -T             | 1 Yes 2 No  27. Manner of Death  | 28a. Date of In                                |                       | ER/Outpatien<br>28b. Time of |  | 4 🗀 190                    |                                    |                             | nce 6 Other (Sp.            | ecify)  |
| O                        | ding<br>h.<br>After<br>fune   | tion           | 1 Natural 5 ☐ Pending  | (Month, D                                      | ay Year)              | Injury                       | 28c. Injury<br>Work  | rat<br>(?<br>Yes 2 □ î     |                                    | Jascilba 110v               | w injury occurred           |   |
| isi                      | Attendi<br>death.<br>ctor: A<br>y fhe fu  | fica           | 3 Suicide 6 Could no   | t be   | niury - At ho         | ome, farm, stre              | eet, factory, office   |                            |                                    | ocation (Stre               | eet and Number or F         | Bural Boute Number                                  |
| <u>S</u>                 | after<br>after<br>Direction   | Certification: | 4 Homicide   | building,                                      | etc. (Specify         | v) -,,                       | ,,,  |                            | 0                                  | ity or Town,                | State)                      |   |
|                          | To the Hospitel or Attending Physicien: within 24 house after deatcors. To the Funerel Districtors. Mile, this certific completely filled in by the funeral director,   |                | 29a. Certifier 1 Certifying  | Physician: To the bes                          | st of my kno          | wledge, death                | occurred at the time   | ne, date and               | d place, and di                    | ue to the cau               | use(s) and manner a         | is stated.  |
|                          | the H<br>sin 24<br>the F<br>pplefe  | Medical        | 51101  | aminer: On the basis<br>and manner s           | stated.               |                              |  |                            | ui occurred at                     |                             |                             |   |
|                          | To To   | ~              | 29b. Signature and title of certifier  | 21   | 1                     |                              | 29c. License   | 20                         | 1                                  |                             | d. Date signed (Mor         |   |
| ,                        | 10  |                | 1/2000   | C/to   |                       |                              | 1  | 1/1                        | 4/                                 | U                           | becompe                     | -21,2003  |
|                          | וט  |                | Name and address of person when the state of | io completed cause of                          | death (Item           | Sales 1                      | Print)   |                            | - 01                               | cs 62                       | un pd.                      | 21061   |
| Ç.                       | - Sta   | to             | 31. Date filed (Marth Day, Year)   | DE Regis                                       | trar's Signa          |                              | SBITAL   | WY                         | 14,57                              | 1 02V                       | me I col.                   | -, 00/  |
|                          | Registr   |                | DEU 3 0'2  | 005  | trar's Signa          | 1908                         | Se de la constante de la const |                            |                                    |                             |                             |   |

|               |   |                  | For State Registrar   | State of M                                      | aryland /                              |                     | artmen<br>rtificate                     |                      |                              | and M     |                                   | giene) ()                   | 5            | 42165                           |
|---------------|---|------------------|---|---|--|---------------------|---|----------------------|------------------------------|-----------|-----------------------------------|-----------------------------|--------------|---------------------------------|
| 7             |   |                  | 1. Decedent's Name (First, Middle, Last   |   |  |                     |   |                      |                              |           | 2. Date of Dea                    | Davi                        | V            | 3. Time of Death                |
|               | Physici<br>/Medic   |                  | Kaymond.  | Dal   | 1                                      |                     |   |                      |                              |           | DECEMA                            | BER ZY                      | Year<br>2005 | - 11.35 AM                      |
|               | Examir  |                  | 4a. Fecility Name (If not institution, give   |   | ,                                      |                     | 4b. City,                               | Town, or             | Location o                   | of Death  |                                   | 4c. Count                   | y of Death   | 1                               |
|               |   |                  | ST. AGNES   |   |  |                     |   |                      | BAL                          |           |                                   |                             |              |                                 |
|               | Funeral   |                  | 5. Social Security Number 6. Se   | x 7. Ag<br>⊋M 2□F                               | ge (In yrs. last                       |                     | If Under<br>Months                      | 1 Year<br>Days       | If Under :<br>Hours          | Min.      | 8. Date of Birtl<br>(Month, Day   | , Year)<br>1930             | Co.          | nplace (State or Foreign        |
| - W           | Director  |                  | Usual Residence of Decedent   | K 221   | 75                                     | Yrs.                |   |                      |                              |           | Oct. 15                           | , 1930                      | Pen          | nśylvania                       |
|               | land  |                  | 10a. State 10b. County  |   | 10c. City, To                          | own or Lo           | cation                                  |                      |                              |           |                                   |                             |              | 10d. Inside City Limits         |
|               | Mary  | ō                | MD Baltime  | ore   | Arbutu                                 | ıs                  |   |                      |                              |           |                                   |                             |              | 1 ☐ Yes 2 ☐ No                  |
|               | 1 the   | rec              | 10e. Street and Number  |   |  |                     | 10f. Zip                                | Code                 | -                            |           |                                   | 10g. Citizen of             | What Co      | untry?                          |
|               | h with  | 0                | 1230 Vogt Ave   |   |  |                     | 2122                                    | 27                   |                              |           |                                   | U.S.A.                      |              |                                 |
|               | death   | Funeral Director | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?               |  | 13.                 | Was Deced                               | ent of Hi            | ispanic Orig                 | gin? (Spe | cify Yes or No-                   |                             |              | ican Indian,                    |
| 9             | or ite  | T                | 1 Never Married 2 Married   | 1 図 Yes 2 口<br>If Yes, Give 2<br>Year or Dates: | No. 18_/19                             |                     | 1 ☐ Yes 2                               |                      |                              | , Pueno   | Rican, etc.)                      |                             | ck, White    |                                 |
| 21215-0036    | within 72 hours after death with the Maryland<br>ane.<br>than "naturef", or items 23a or 28e-f show<br>ta Moulgal Exercities Last for incitited at  | d by             | 3 ☐ Widowed 4 ♣ Divorced  | Year or Dates:                                  | 2-17-50                                | )                   | 103 2                                   | : PG 140             | Specify.                     |           |                                   | Specil                      | y: Wh        |                                 |
| 5-            | 72 h  | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  |   | 16                                     | 6a. Deced<br>(Give  | dent's Usua<br>kind of wor<br>DO NOT us | l Occupa<br>k done d | ation<br><i>during m</i> ost | of workii | ng                                | 16b. Kind of B              |              | ndustry                         |
| 121           | within<br>ne.   | ם                | Elementary/Secondary (0-12)   | College (1-4or                                  | 5+)                                    |                     | ce Wo                                   |                      |                              |           |                                   | Maryla                      |              |                                 |
|               | fygie<br>fygie<br>ther i  |                  | 17. Father's Name (First, Middle, Last)   |   |  | servi               | .ce wc                                  | rke                  |                              | r's Namo  | (First, Middle,                   | State                       |              | oyee                            |
| ano           | ntal ed o   | Be c             | Charles Day   |   |  |                     |   |                      | _                            |           | Mauses                            | Maidell Sullar              | 116)         |                                 |
| Maryland      | 12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic event, It a Men   | 은                | 19a. Informant's Name/Relationship (Ty  | roe Print)                                      | 1                                      | 9h Mailir           | na Address                              | (Street :            | and Numbe                    | r or Rura | l Route Numbe                     | r City or Town              | State 7      | in Code)                        |
| S             | iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "naturef", or items 23a or 28e-f show or other traumatic event, if a Medical Examiner man be notified at |                  | Margaret C. Dowling   |   |  |                     |   |                      |                              |           | s MD 212                          |                             | , otato, E   | <i>p</i> 0000)                  |
| ē,            | permit. Pages 1 and:<br>Department of Health<br>Important: If Item 27<br>any injury or other tr.<br>2009.   |                  | 20a. Method of Disposition  |   | 20b. Place                             | of Dispo            | sition (Nam                             | e of                 |                              | D         | ate                               | 20c. Location               | - City or T  | Town, State                     |
| Baltimore,    | Pages<br>nent of H<br>int: If its<br>iry or of  |                  | 1 ☐ Burial 2 ☒ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  | lemoval from State                              | Bayvi                                  | Lew C               | remat                                   | ory                  | 9) ; .                       | 12-28     | 3-2005                            | Baltimo                     | re, l        | MD                              |
| alti          | permit. Pag<br>Department<br>Important: f<br>any injury o   |                  | 21. Signature of Funeral Service Licens   | 96  |  | 22                  | . Name and                              | d Addres             | s of Facility                | y         |                                   |                             |              |                                 |
| m             | Dep Pen   |                  | Le pelus  |   | ~                                      | A                   | mbros<br>328 S                          | e Fu                 | inera<br>Jur Si              | l Hon     | ne,Inc.                           | Arhutus                     | MD '         | 21227                           |
|               | अं  |                  | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only or                               | ications that caused                            | d the death. D                         |                     |   |                      |                              |           |                                   |                             |              | Approximate<br>Interval Between |
| J.            | Physician   |                  | Immediate Cause (Final disease or condition   |   |  | nudi                | , 01-                                   | 7 - 4 v              | ,                            |           |                                   |                             |              | Onset and Death                 |
|               | /Medical  |                  | resulting in death)   |   | ENCE a consequence                     |                     |   |                      |                              |           |                                   |                             |              | - 60 229                        |
| •             | Examiner  |                  | Sequentially list conditions,   | Pissibl   | e STA                                  | OKE                 | YS                                      | Bin                  | n Met                        | 45        |                                   |                             |              | for day                         |
|               | pe iis  | lne              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                                   | a consequenc                           | ce of):             |   |                      |                              |           |                                   |                             |              | - /                             |
|               | and<br>I-tran   | Examiner         | that initiated events resulting in death) Last  | Due to (or as                                   | a consequence                          |                     |   |                      |                              |           |                                   |                             |              | Few Years                       |
| 68760,        | death certificate be executed<br>e attending physicien and<br>of for use as the burial-transit  |                  | l l   |   |  | , .                 |   |                      |                              |           |                                   |                             |              |                                 |
| 687           | ficate<br>physics the   | edical           |   | J   |  |                     | -                                       |                      |                              |           |                                   |                             |              |                                 |
| Вох           | eath certific<br>attending p  | N/               | IF FEMALE:<br>23b. Was decedent pregnant  | 3c. If yes, outcome                             |  |                     |   |                      |                              |           |                                   | 23d Da                      | te of deliv  | (ADV                            |
|               | death<br>a atte<br>d for  | cla              | in the past 12 months?  | 1 ☐ Live birth<br>4 ☐ Pregnant at               |  |                     | Ectopic pre<br>Other (spe               |                      |                              |           |                                   |                             | onth         | Day Year                        |
| P.0           | thet the de<br>ned by the a   | Physiclan/Me     | 9 ☐ Unknow <i>n</i>   | 9□ Unknown                                      |  |                     |   |                      |                              |           |                                   |                             |              |                                 |
| ď.            | Physician: The law requires thet the this certificate has been signed by the didicate, page 2 should be detached.   | by P             | Part II. Other significant conditions con   |   | •                                      |                     |   | iuse give            | n in Part I.                 |           | 23e. Did to                       | bacco use con               | tribute to   | the cause of death?             |
| ğ             | w require<br>been signature   |                  | COPD, lung  | encer,  | PARKIN                                 | SONIS               | m                                       |                      |                              |           | 1 🗆 Y                             | es 2 No                     | 3 Pro        | bably 4 Unknown                 |
| ပ္တ           | law re<br>as be<br>2 sho  | ple              |   |   |  |                     |   |                      |                              |           | 24a. Was a                        |                             | Were aut     | opsy findings available         |
| ital Records, | The lav   | Completed        |   |   |  |                     |   |                      |                              |           | autops<br>perfori                 | med?                        | death?       | ompletion of cause of           |
| ita           | ician: Th<br>certificate<br>rector, pag   | Be               | 25. Was case referred to medical examiner?  |   |  |                     |   |                      | 26. Place                    | of Death  | Check only or                     | 7.71.00                     |              |                                 |
| Ž             | shysic<br>this ce<br>al dire  | 2                | 1 ☐ Yes 2 ☐ No  | lospital:                                       |  | Outpatien           | t 3 DO                                  | A Othe               | er: 4 🗆 Nur                  | rsing Hon | ne 5 🗆 Reside                     | ence 6 Oth                  | er (Speci    | fy)                             |
| n<br>O        | e je n  | on:              | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Inju<br>(Month, Da                 | y Year) 28b                            | . Time of<br>Injury |   | Bc. Injury<br>Work   |                              |           | 28d. Describe ho                  | ow injury occur             | red          |                                 |
| sio           | r Attending<br>er death.<br>rector: After<br>by the funer   | cati             | 2 Accident investigation 3 Suicide 6 Could not be   |   |  |                     | М                                       |                      | /es 2□N                      |           |                                   |                             |              |                                 |
| Division of   | i Sir o   | Certification:   | 4 ☐ Homicide determined   | 28e. Place of Ini<br>building, et               | ury - At home,<br>ic. <i>(Specify)</i> | tarm, str           | eet, factory,                           | office               |                              | 2         | 281. Location (Si<br>City or Town | treet and Numb<br>n, State) | er or Rur    | al Route Number,                |
| ]             | To the Hospital or within 24 hours afte To the Funerel Dir completely filled in   |                  | 29a. Certifier 1 Certifying Phys  | sician: To the best                             | of my knowled                          | Ide doath           | Occurred -                              | it the time          | o data                       | d place   | and due to the                    | auna/=\ === 1               |              |                                 |
|               | 24 h<br>24 h<br>Fur<br>etely  | Medical          | (Check only 2 Medical Examinations)   | ner: On the basis of                            | t examination                          | and/or inv          | estigation,                             | in my op             | pinion, deat                 | h occurre | ed at the time, d                 | ate and place.              | and due t    | o the cause(s)                  |
|               | To the Ho<br>within 24 I<br>To the Fu<br>completely   | Me               | 29b. Signature and title of certifier   |   |  |                     | 29c.                                    | License              | number                       |           | 2                                 | 9d. Date signe              | d (Month,    | Day, Year)                      |
|               |   |                  | Mil   | - MD  | )                                      |                     | 1                                       | 00                   | 62634                        | 1         |                                   | 12/24                       | 105          |                                 |
| •             | L'X   |                  | 30. Name and address of person who co   | impleted cause of d                             | leath (Item 23a                        | a) (Type, I         | Print)                                  |                      |                              |           |                                   | /                           | /            |                                 |
|               | 5'  |                  | MATERN A.   | ALLAN .   | 2717 H                                 | AMN                 | 10.005                                  | FEA                  | Ry Lo.                       | 10        | BALTIM                            | 1. RE M                     | 0 21         | 227                             |
|               | Sta<br>Registr  |                  | 31. Date filed (Month, Day, Year) DEC 3 0 2005  | and manner sta                                  | rar's Signature                        | Logi                | 820                                     |                      |                              |           |                                   |                             |              |                                 |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Beatrice Dietrich 20:SS Dumber 2005 /Medical 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Baltimore Barriew Medical Center N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number **Funeral**  Birthplace (State or Foreign Country) 1 M 2 KF Months Director 212-28-4368 Maryland April 24,1912 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iteme 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 2710 Tilden Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No ģ Specify: Specify: 3 Midowed 4 ☐ Divorced "naturel", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na eny injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Daniel Walter Eklund Florence Josephine Cavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy O. Dietrich (Daughter) 2710 Tilden Road Dundalk, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 12/30/2005 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 9 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Septu shock /Medical Examiner nfection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Author stenosis 1 Yes 2. No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 Ø No 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl

To the Funaral Director:
completely filled in by the 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES DOD D-ember 2+ 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Bayview Med. Ctr. Maria Said, M.D. 4940 Eastern Ave. Baltimore, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 3 0 2005

|                                |  |                | For<br>State<br>Registrar   | State of Ma                                     | aryland           |                             | rtment of H  |   |  | giene<br>2ND 05                       | 42167   |
|--------------------------------|--|----------------|---|---|-------------------|-----------------------------|--|---|--|---------------------------------------|---|
|                                |  |                | Decedent's Name (First, Middle, La  | st)   |                   |                             |  |   | 2. Date of Dea<br>Month                  | ith                                   | 3. Time of Death  |
|                                | Physicia<br>/Medic   |                | Carl Field  |   |                   |                             |  |   | December                                 | 22 200                                |   |
|                                | Examin   | er             | 4a. Facility Name (If not institution, giv  | _   |                   |                             | 4b. City, Town, or Balti   | Location of Death                         |  | 4c. County of                         |   |
| 6                              | Funeral  | 4              | Joseph Richey H 5. Social Security Number 6. S  |   | e (In yrs. las    | st birthday)                | If Under 1 Year  | If Under 24 Hrs.                          | 8. Date of Birth                         |                                       | 9. Birthplace (State or Foreign                                   |
|                                | Director   |                | 217 10 0433   | <b>∆</b> M 2□F                                  | 78                | Yrs.                        | Months Days  | Hours Min.                                | 8. Date of Birth<br>Month, Day<br>APR 13 | 1927                                  | NC NC   |
|                                | land<br>ow   |                | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City,        | Town or Lo                  | cation   |   |  |                                       | 10d. Inside City Limits   |
| 0                              | e-feh  | ctor           | MD N/A  |   | Ва                | ltimo                       | re   |   |  |                                       | 1 X Yes 2 □ No  |
|                                | or 28  | Director       | 10e. Street and Number  | A   |                   |                             | 10f. Zip Code  | .213                                      |  | 10g. Citizen of WI<br>USA             | hat Country?  |
|                                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 ie marked other then "naturel", or items 23a or 28e-f ehow any Injury or other treumatic event, Ite Medical Examinat must be notified at once.  | Funeral        | 1732 N. Montford  | 12. Was Decedent                                | Ever in U.S.      | 13. V                       | Vas Decedent of Hi   |   | pecify Yes or No-                        |                                       | - American Indian,  |
| 9                              | after d<br>or Iten   |                | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 X ! If Yes, Give        |                   | l1                          | Yes, specify Cuba  | n, Mexican, Puerto                        | Rican, etc.)                             | Black                                 | , White, etc.   |
| 003                            | hours<br>ural',  | d by           | 3 X Widowed 4 □ Divorced  | Year or Dates:                                  |                   |                             |  |   |  | Specify:                              | Black   |
| -51                            | in 72<br>n "nat  | Completed      | 15. Decedent's E<br>(Specify only highest gra   | ide completed)                                  |                   | (Give life. L               | ent's Usual Occupa<br>kind of work done o<br>OO NOT use retired, | ation<br>furing most of work<br>)         | king                                     | 16b. Kind of Bus                      | iness/industry  |
| 212                            | d with   | Com            | Elementary/Secondary (0-12)   | College (1-4or 5                                |                   | Opera                       | tor  |   |  | Chemical                              | l Plant   |
| pur                            | be file<br>ad oth  | Be             | 17. Father's Name (First, Middle, Last  |   |                   |                             |  | 18. Mother's Nam<br>Annie                 | ne (First, Middle,<br>Clemer             | Maiden Sumame,                        | )   |
| 12/2                           | should<br>nd Mer<br>mark   | ٦              | Carl Fields  19a. Informant's Name/Relationship (   | Type, Print)                                    |                   | 19b. Mailin                 | g Address (Street a  |   |  |                                       | State, Zip Code)  |
| <b>≥</b>                       | alth ar<br>27 le   |                | Vanceane Major -  | niece   |                   |                             | Lyndale A  |   |  | -                                     | 1213  |
| Baltimore, Maryland 21215-0036 | of He of He or other   |                | 20a. Method of Disposition 1 Durial 2 XCremation 3 D  | Removal from State                              | 20b. Pla          | ce of Dispo<br>netery, cren | sition (Name of<br>natory or other place                         | θ)  | Date                                     |                                       | City or Town, State   |
| ii.                            | it. Pag<br>rtment<br>rtant:<br>njury c   |                | 4 ☐ Donation 5 ☐ Other (Specif  | y)  | Ches              |                             | ce Cremat  |   | -  | Beltsvil                              | le, MD  |
| Bal                            | Departing Department of the post of the po |                | 21. Signature of Funeral Service Licer  | 1500  | M0098             | 6                           | Name and Addres<br>AFA, Step<br>717 Greer                        | bhen D. L<br>Pasture                      | ohrmann.<br>s Drive                      | , PA<br>Towson                        | . MD 21286  |
|                                | y , 10 -   |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only   | plications that caused<br>one cause on each lii | the death.<br>ne. |                             | er the mode of dying   | g, such as cardiac                        | or respiratory ari                       |                                       | Approximate Interval tween On and Death                           |
|                                | Physician  |                | Immediate Cause (Final disease or condition resulting in death)   | a Lar   | Valle             | 7/                          | CAYO   | MON                                       | na                                       |                                       | SV/3  |
|                                | /Medical<br>Examiner   |                | - (   | Due to (or a                                    | co seque          | nce of):                    |  |   |  |                                       | 1   |
|                                |  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or as                                | a conseque        | nce of):                    |  |   |  |                                       |   |
| 11                             | ecuted<br>and<br>transi  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last   | C. Due to for an                                |                   |                             |  |   |  |                                       |   |
| 1/100                          | cate be executed<br>physician and<br>the burial-transit  | dicai E        | ,   | Due to (or as                                   | a conseque        | nce or).                    |  |   |  |                                       |   |
| 1 1 88                         | tificate<br>ng phys<br>as the  | Medic          | 75 FF1111 F   | . U   |                   |                             |  |   | ~  |                                       |   |
| M. X.                          | death certifi<br>e ettending<br>d for use as   | lan/\          | IF FEMALE;<br>23b. Was decedent pregnant<br>in the past 12 months?  | 23c. If yes, outcome<br>1☐Live birth            | 2 Fetal d         | eath 3                      | Ectopic pregnancy  |   |  | 23d. Date                             | of delivery<br>h Day Year   |
| 0.                             | w requires that the death certific<br>been signed by the ettending f<br>should be detached for use as  | Physician/Me   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4∏Pregnant at<br>9☐ Unknown                     | time of dea       | th 5                        | Other (specify)  |   |  |                                       | 54, 754.  |
| 10                             | s that<br>ned by<br>e deta   | by Ph          | Part II. Other significant conditions   | ontributing to death b                          | ut not resulti    | ing in the ur               | derlying cause give  | en in Part I.                             | 23e. Did to                              | b use contrib                         | oute to the cause of death?                                       |
| " Br                           | equire<br>en sig<br>ould b   |                |   |   |                   |                             |  |   | 124                                      | es 2□No 3                             | B Probably 4 Unknown  |
| Division of Vital Recor        | E 25 C   | Completed      |   |   |                   |                             | <u> </u>   |   | 24a. Was a autops perfor                 | an 24b We                             | ere autopsy findings available for to completion of cause of ath? |
| Tal F                          | sicien: The lav<br>certificate has<br>rector, page 2   |                | 25. Was case referred to medical  |   |                   |                             |  | 00 81                                     | 1 ☐ Yes                                  | 200 1E                                | Yes 2 No  |
| ₹                              | Physicien:<br>this certificanal director,  | To Be          | examiner  | Hospital:                                       | nt 2 EF           | VOutpatien                  | 3 DOA Othe   | 26. Place of Dear                         | tn (Cneck only or<br>ome 5 ☐ Resid       |                                       | (Specky DAN)/   |
| 0                              | ding Phys<br>I.<br>After this<br>funeral di  |                | 27. Manuer of Death 1 Natural 5 Pending   | 28a. Date of Inju<br>(Month, Da                 | ry 2<br>y Year)   | 8b. Time of<br>Injury       | 28c. Injury<br>Work  | at<br>?                                   |  | ow injury occurred                    | o Hayer   |
| isio                           | death.   | Certification: | 2 Accident investigation 3 Suicide 6 Could not b  | e 00- Di  | un. At hom        | e farm stre                 |  | Yes 2 □No                                 | 28f Location (S                          | treet and Number                      | or Rural Route Number,  |
| Div                            | after a safter I Direct  | ertii          | 4 Homicide determined   | building, et                                    | c. (Specify)      | e, taliii, sile             | odi, factory, office   |   | City or Tow                              | n, State)                             | or Notal Notice Number,   |
|                                | To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funerel Director: After this certificate ht completely filled in by the funeral director, page  | Medical C      | 29a. Certifier 12 Certifying Pt (Check only one)  | niner: On the basis of                          | examinatio        | ougo, death<br>n and/or inv | occurred at the time<br>estigation, in my op                     | e, date and place,<br>pinion, death occur | and due to the e                         | ausa(s) and man<br>late and place, an | nor as statud.<br>nd due to the cause(s)                          |
|                                | Vithin 1   | Mec            | 29b. Signature and title of certifier   | and manner sta                                  | 118U.             |                             | 29c. License   |   |  |                                       | (Month, Day) Year)  |
|                                |  |                | > /Mu Pa  | UME N   | 11)               |                             | Dis  | 30/2                                      |  | 12/2                                  | 14/05   |
|                                | 2  |                | 30. Name and address of person who  | completed cause of d                            | eath (Item 2      | 3a) (Typ).                  | Print)   | 1 Al                                      | B41                                      | L. A                                  | 1/ 2/2/0  |
|                                | Sta  | te             | 31. Date filed (Month, Day, Year)   | 32. Registr                                     | ar's Signatu      | 11/1/1                      | 11000  | 1 /4                                      | VojTe                                    | 1. 11/1                               | is Holy   |
|                                | Registr  | -              | DEC 3 0 200   | 5 Condines                                      | 1.                | Speak                       |  |   |  | 8                                     |   |

|             |   |                | 1 - For<br>State<br>Registrar   | State of Ma                               | aryland / Depa<br><i>Cel</i>         | artment of H                               |               |  | giene<br>Reg. No.   | 15              | 2168   |
|-------------|---|----------------|---|---|--------------------------------------|--|---------------|--|---------------------|-----------------|--|
| F           | • Physici   | an             | 1. Decedent's Name (First, Middle, L  | ast)                                      | ***                                  | ( .(                                       | <u></u>       | 2. Date of De                                |                     | Year            | 3. Time of Death                                   |
|             | /Medio  | al             | Martin &  | dward                                     |                                      | Orit.                                      | tin           | Jr. Decembe                                  | er 25               | 2005            |  |
|             | Examir  | er             | 4a, Facility Name (If not institution, gi   | ve street and number)                     | 1- 11                                | 4b. City, Town, or                         | 1             | Death '                                      | 4c. Cou             | inty of Death   |  |
|             | Funeral   | 63             |   |   | (In vis. last birthday)              | If Under 1 Year                            | If Under 2    | 4 Hrs. 8. Date of Bir                        | th                  | 9. Birthr       | place (State or Foreign                            |
| Ŀ           | Director  |                | 216-52-3549   | 1 □ XM 2 □ F                              | 54 Yrs.                              | Months Days                                | Hours         | Min. May 6,                                  | <sup>iy.</sup> 1951 | Cou             | ntry)<br>Tand                                      |
|             | and *   |                | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town or Lo                | ocation                                    |               |  |                     |                 | 10d. Inside City Limits                            |
|             | Maryli<br>f sho   | ō              | MD Caroli   | ne .                                      | Federals                             |  |               |  |                     |                 | 1 ☐Yes 2 ☐ No                                      |
|             | r 28a-  | Director       | 10e. Street and Number  | 10  | rederais                             | 10f. Zip Code                              |               |  | 10g. Citizen        | of What Cou     | Λ  |
|             | th with   | a D            | 525 Liberty Road  | 1   |                                      | 21632                                      |               |  | USA                 |                 | •  |
|             | r dea   | Funeral        | 11. Marital Status  | 12. Was Decedent B<br>Armed Forces?       | Ever in U.S. 13.                     | Was Decedent of Hi                         | spanic Origin | n? (Specify Yes or No<br>Puerto Rican, etc.) | - 14. F             | Race - Americ   |  |
| 36          | s afte<br>; or if   | by Fu          | 1 Never Married 2 Married 3 Widowed 4 Divorced  | 1 ☐ Yes 2 ▼ N<br>If Yes, Give             | 10                                   | 1 □ Yes 2 No                               | Specify:      | ,  |                     |                 | hite   |
| 21215-0036  | 72 hours after death with the Maryland<br>neturel; or items 23s or 28s-f show<br>Jical Evaculaer mast be rediffed at  |                | 15. Decedent's B  | Year or Dates:                            | 16a. Dece                            | dent's Usual Occupa                        | ation         |  | 16b Kind o          | f Business/In   |  |
| 215         | within 72<br>ene.<br>then "ne   | plet           | (Specify only highest gi  | rade completed)  College (1-4or 5         | (Give                                | kind of work done of<br>DO NOT use retired | luring most c | of working                                   | 100. 70110          | Businosayın     | dustry   |
|             | e filed within<br>al Hygiene.<br>other then '<br>vent, the Me   | Completed      | 12  |   | P1um                                 | ber  |               |  | Const               | ructio          | n  |
| and         | be fill<br>tal Hy<br>d oth  | Be             | 17. Father's Name (First, Middle, Las<br>Martin Edward G  |   |                                      |  |               | s Name (First, Middle,                       | Maiden Sun          | атө)            |  |
| Maryland    | should<br>nd Men<br>marke<br>umatic   | 임              | 19a. Informant's Name/Relationship  |   | 10b Mailir                           | a Address (Street s                        |               | rothy Carr                                   | C. C. T.            | Cana 7:         | - 0 - 4-)  |
|             | nd 2 s<br>lith an<br>27 is<br>r treu  |                | Patricia Ann Jac  | kson - Sis                                | ter 9 Law                            | ler Ave                                    | Lurav         | . VA 22835                                   | on, ony or roi      | wii, State, Zip | Code)  |
| Jre,        | es 1 and 2<br>of Health<br>I item 27 I  |                | 20a. Method of Disposition  |   | 20b. Place of Dispo                  | sition (Name of<br>natory or other place   |               | Date   |                     | on - City or To | own, State   |
| <u>ii</u>   | Pages<br>nent of I<br>ant: If its<br>ury or o   | - 0            | 1 XBurial 2 □ Cremation 3 ( '4 □ Donation 5 □ Other (Spec   |   | 1.                                   | Cemetery                                   |               | 2/28/05                                      | Lura                | y, Vir          | ginia  |
| Baltimore,  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depurtment of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23s or 28s-f show any njury or other treumatic event, the Medical Exercited final be rediffed at once. |                | 21. Signature of Funeral Service Lice   | nsee                                      | 000 22                               | 2. Name and Addres                         | s of Facility | Bradley F                                    |                     |                 |  |
|             | 007 e 0   |                | Julen J.  | MODIA                                     | YYY                                  |  |               |  |                     | Luray           | , VA 22835   |
| Ŋ           |   |                | 23a. Part1. Enter the disease, or cor<br>shock or heart failure. List only<br>Immediate Cause (Final                              |   |                                      | er the mode of dying                       | g, such as ca | ardiac or respiratory a                      | rest,               |                 | Approximate<br>Interval Between<br>Onset and Death |
|             | Pnysician<br>/Medical   |                | disease or condition resulting in death)  | a   | PSIS<br>a consequence of):           |  |               |  |                     |                 | 4 days   |
|             | Examiner  |                |   |   | ntaneous                             | Backria                                    | 2 Peri        | tenitis and                                  | Preux               | nenia           | Juneales   |
|             | p =   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a                           | a consequence of):                   |  |               |  | 111004              | (ortion)        | 2 10 (612)   |
|             | ecute<br>and<br>trans   | Examine        | Cause (Disease or injury that initiated events resulting in death) Last   | C.  | rhosis                               |  |               |  |                     | 6               | Lyears   |
| 8760,       | cate be executed<br>physician and<br>the burial-transit   | al E           | Totaling in South / 200   | Due to (or as a                           | a consequence of):                   | 2 and                                      | 10            |  |                     | ١.              | le.  |
| 687         | ficate<br>g phys  | edical         |   | d   | 1777                                 | unu  |               |  |                     |                 | inknown  |
| Вох         | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of                   |                                      | Tatania araanaa                            |               |  | 23d. I              | Date of delive  | ery  |
|             | es that the death cer<br>igned by the attendir<br>be detached for use   | sicle          | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 4☐Pregnant at                             |                                      | Ectopic pregnancy Other (specify)          |               |  | 1                   | Month           | Day Year   |
| P.0         | hat the<br>d by t<br>letach   | Phy            | 9 ☐ Unknown  Part II. Other significant conditions  |   | at not requibles in the un           |  |               | age Did to                                   |                     |                 |  |
| ds,         | signed I  | by             | Agute Ren   | al Fail                                   | 1.111 Q                              | ideriying cause give                       | п п Рап I.    | 23e. Dia to                                  | l.                  |                 | ne cause of death?<br>ably 4 □Unknown              |
| Record      | w requir<br>been si<br>should   | lete           | Manatio E   | penal-ala                                 | anthu                                |  |               | 24a. Was                                     |                     |                 |  |
| Re          | ding Physician: The lav<br>h.<br>After this certificate has<br>funeral director, page 2   | Completed      | Coambopath  | MI Francis                                | garage                               |  |               | autop<br>perfo                               | sy<br>med?          | death?          | psy findings available<br>inpletion of cause of    |
| Viital      |   | 0              | 25. Was case referred to medical  |   |                                      |  | 26. Place of  | 1 ☐ Yes<br>f Death Check onlo                | 2)S-No              | 1 🗆 Yes         | 212No  |
|             | Physic<br>this ce<br>al direc   | To B           | examiner?<br>1 ☐ Yes 2 XNo  | Hospital: Inpatier                        | nt 2 ER/Outpatien                    | t 3 DOA Othe                               | r             | ing Home 5 - Resid                           |                     | ther (Specify   | 1)   |
| Division of | Attending Physician: r death. sctor: After this certific by the funeral director.   | on:            | 27. Manner of Death  1 Natural 5 □ Pending  | 28a. Date of Injun<br>(Month, Day         |                                      | Work                                       | ?             | 28d. Describe h                              | ow injury occ       | urred           |  |
| isio        | deatl<br>ctor:<br>/ the   | Certification: | 2 Accident investigation 3 Suicide 6 Could not to   | OO Diseased lain                          | ry - At home, farm, stre             |  | es 2 □ No     |  | Stroot and New      | mbor or Pusa    | l Route Number,                                    |
| <u>&gt;</u> | al or A<br>after<br>I Direct  | ertii          | 4 Homicide determined   | building, elc.                            | . (Specify)                          | sot, factory, office                       |               | City or Tou                                  |                     | ilber or mura.  | r Addie Number,                                    |
|             | Hospitel or Attend<br>44 hours after death<br>Funerel Director:<br>18ly filled in by the  |                | 29a. Certifier 1 Certifying P   | hysician: To the best o                   | f my knowledge, death                | occurred at the time                       | e, date and p | place, and due to the                        | ause(s) and         | manner as st    | ated.  |
|             | To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the  | ledical        | 0.107   | miner: On the basis of<br>and manner stat | lea.                                 |  |               |  |                     |                 |  |
|             | Twitt<br>Con  | Σ              | 29b. Signature and title of certifier   | 47  | L 21 0                               | 29c. License                               | number        | 500  | 29d. Date sign      | ied (Month, L   | Day, Year)   |
| •           | d   |                | 30. Name and address of person who  | completed cause of de                     | 7 / W                                | Print)                                     | ) (           |  | KCembi              | 21 2            | 5,0005   |
| 1           |   |                | Rosesh Gupta  | completed cadse of de                     | path (Item 23a) (Type, In 1960 North | h Wolfe                                    | Stre          | get, Balt                                    | more,               | MO .            | 21287  |
| 4           | Sta   |                | 31. Date filed (Month, Day, Year)   | 2. Registra                               | r's Signature                        | W  |               |  |                     |                 |  |
|             | Registr   | ar             | DEC 3 0 20  | JJ Jackson                                | - 1                                  |  |               |  |                     |                 |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month /Medical Ann Ellen Gable 12 26 2005 5:06 PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Gilchrist Center Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Yrs. Director 216-28-6283 76 05/31/1929 Maryland Usual Residence of Decedent death with the Maryland 10a. State 7 is marked other than "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2X No MD Baltimore Baldwin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4747 Sweet Air Road Funerai 21013 U,S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No 2 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than ", any hiury or other traumatic event, the Mexant place. Baltimore Elementary/Secondary (0-12) College (1-4or 5+) 12 County School School Bus Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Melvin Harrison Sarah Elisa Isennock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine R. Eyre (daughter) 11710 Hillside Road - Kingsville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ▼Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. 12/29/2005 Timonium, Maryland 22. Name and Address of Facility E.F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6 ass 11750 Belair Road - Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Brain Onset and Death **Physician** acontas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2D No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Satural 5 Pending death. 2 Accident investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours.
the Funeral Direction of filled in Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 158302 December 27 2005

10

State Registrar 31. Date filed (Month, Day, Year) DEC 3 0 2005

AMON

32 Registrar's Signature

6600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

conces

mo

N. Charles St Borgmone no 21200

Sable, Ellen

LAURA GARDNER 05-08724 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PLI,27,perME,0851,1/11/06 TI

|                            |  |                  | 1 - For<br>State<br>Registrar   | State of Maryla  |                        | ment of Health a<br>ficate of Death                                     |              | ental Hygie<br>Reg                  | 11115                          | 42170  |
|----------------------------|--|------------------|---|--|------------------------|---|--------------|-------------------------------------|--------------------------------|--|
|                            | Physic   | an               | Decedent's Name (First, Middle, Li  | isti   |                        |   |              | 2. Date of Death<br>Month           | Day Year                       | 3. Time of Death                                   |
|                            | /Medi  | cal              | Laura   | garaner  |                        |   |              | DECEMBER                            | 24, 2005                       | 6:57P. <sup>™</sup>                                |
|                            | Exami  | er               | 4a. Facility Name (If not institution, gi<br>BON SECOURS HOSP   |  | 4                      | b. City, Town, or Location of<br>BALTIMORE                              | of Death     |                                     | 4c. County of Deal             | h<br>A   |
| 3                          | Funeral  |                  |   |  |                        | f Under 1 Year   If Under   | 24 Hrs.      | B. Date of Birth<br>(Month, Day, Y) | 9. Birt                        | hplace (State or Foreign                           |
| 0                          | Director   |                  | 212-48-3548   | 10M 201F 64  | Yrs.                   | Months Days Hours   | Min.         | 149.16, (                           | 941 M                          | aculand  |
| 0                          | and *  |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. (   | ity, Town or Locat     | ion   |              | J                                   |                                | 10d. Inside City Limits                            |
|                            | the Marylar<br>28a-f ehow  | ō                | Maryland All  | 4  | D ~ 11.                |   |              |                                     |                                | 1 XYes 2 No  |
|                            | r 28a  | rec              | 10e. Street and Number  |  | Daily                  | YOLE<br>10f. Zip Code   |              | 10g.                                | . Citizen of What Co           |  |
|                            | death with the Maryland<br>ms 23s or 28s-f show<br>(must be notified at  | at D             | 1161 N. Cal   | houn St.   |                        | 21217   |              |                                     | 115+                           | 7  |
|                            | 's after death with the Maryla's', or Items 23a or 28a-f eho   | Funeral Director | 11. Marital Status  | 12. Was Decedent Ever in Armed Forces?                           | U.S. 13. Wa            | s Decedent of Hispanic Ories, specify Cuban, Mexican                    | gin? (Spec   | ify Yes or No-                      | 14. Race - Ame<br>Black, While | rican Indian,                                      |
| 36                         | s afte   | by Fu            | 1 Never Married 2 Married<br>3 Widowed 4 Divorced   | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:                 |                        | Yes 2 No Specify:   |              | ,                                   | Specify: 7                     | 101/   |
| Maryland 21215-0036        | filed within 72 hours after<br>Hygiene.<br>ther then "neturel", or ite<br>int, the Medical Exertine                          | edt              | 15. Decedent's E  | ducation   | 16a, Deceden           | t's Usual Occupation  |              | 161                                 | o. Kind of Business/           | lack   |
| 215                        | thin 7:  | Be Completed     | (Specify only highest gi  | ade completed)  College (1-4or 5+)                               | (Give kin<br>life. DO  | t's Usual Occupation<br>of of work done during most<br>NOT use retired) | t of working | '                                   | O ( )                          | industry .   |
| 21                         | be filed within tal Hygiene. Ind other then event, the Meren   | Con              | 12  | O  | ta                     | ctory W   | orK          | er                                  | Poult                          | 4  |
| and                        | B E S  | Be               | 17. Father's Name (First, Middle, Las.  |  |                        | 18. Mothe   | r's Name (   | First, Middle, Mai                  | den Sumame)                    | /  |
| Ž                          | s 1 and 2 should<br>I Health and Men<br>Item 27 ie marke<br>other treumatic  | ဥ                | Sherman  19a. Informant's Name/Relationship   | Gardner  |                        | Address (Street and Number  | 215          | Y [V]                               | attheu                         | (5   |
| Ma                         | D = 2 F  |                  | Mr Alton le   | 2 Cmith  | 3411                   | AUFORA  | GNO          | Gull                                | con Dal                        | / MJ 21209   |
| Je,                        | of Head<br>of Head<br>fitem<br>rothe   |                  | 20a. Method of Disposition  |  | Place of Disposition   | on (Name of   | /. /Dai      | 9 200                               | Location - City or             | Town, State  |
| altimore,                  | Page<br>ment g<br>ant: if  |                  | 1 Ø Burial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Speci   |  | At. Car                | mel   | 13/20        | 06                                  | undal                          | K Md   |
| Balt                       | permit. Pages<br>Depertment of<br>Important: If I<br>eny Injury or o   |                  | 21. Signature of Funeral Service Lice   | nsee Q (D  | 22. N                  | ame and Address of Facility   | y E          | . La creat                          | Hama D                         | Δ  |
|                            | 40204  |                  | 220 Part 1 Star the discuss of an   | J. Dus   | 1 222                  | J.M. North  | Ave          | Bail to                             | Maizizi                        | 6  |
|                            |  |                  | 23a. Part1. Inter the disease, or con<br>shock or heart failure. List only<br>Immediate Cause (Final            |  |                        |   |              |                                     |                                | Approximate<br>Interval Between<br>Onset and Death |
|                            | Physician /Medical   |                  | disease or condition resulting in death)  | a. Hypertensive a  |                        | otic cardiovascu  | ılar di      | sease                               |                                |  |
|                            | Examiner   |                  |   | Due to (or as a conse  | querice or).           |   |              |                                     |                                |  |
|                            | D #  | ner              | Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse  | quence of).            |   |              |                                     |                                |  |
|                            | and<br>-trans  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last   | c  |                        |   |              |                                     |                                |  |
| 68760,                     | icate be executed<br>physicien and<br>s the burial-transit   |                  |   | Due to (or as a conse  | querice or):           |   |              |                                     |                                |  |
| 687                        | = 73.9   | edicat           |   | . d  |                        |   |              |                                     |                                |  |
| Вох                        | death certiff<br>e ettending<br>id for use as  | Z                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregr                                    |                        |   |              |                                     | 23d. Date of deli-             | very   |
|                            | e deal   | Physician/M      | in the past 12 months?<br>1 □ Yes 2 ②No   | 1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown |                        | opic pregnancy<br>her (specify)   |              |                                     | Month                          | Day Year   |
| P.0                        | res that the de<br>igned by the c<br>be detached to  | Phy              | 9 ☐ Unknown  Part If. Other significant conditions of   |  |                        |   |              |                                     |                                |  |
| Division of Vital Records, | requires t<br>sen signe<br>nould be c  | Completed by     | Chronic Alcoholism,   |  | suring in the thidel   | lying cause given in Part I.  |              |                                     | couse contribute to            | the cause of death?                                |
| S                          |  | lete             | The shadeline   |  |                        |   |              |                                     |                                |  |
| Re                         | sicien: The law<br>certificate has b<br>irector, page 2 s  | dmo              |   |  |                        |   |              | 24a. Was an autopsy performed       | ?   death?                     | opsy findings available<br>empletion of cause of   |
| ita                        | ien:<br>rtifice<br>stor, p   | BeC              | 25. Was case referred to medical  |  |                        | 26 Place  | of Death //  | 1⊠ Yes 2□                           | No 1 🖫 es                      | 2 □ No   |
| <u>&gt;</u>                | Physicien:<br>r this certifice<br>ral director, p  | 2                | examiner?<br>1∭ Yes 2 □ No  | Hospital: 1 ☐ Inpatient 2 🗓                                      | ER/Outpatient          |   |              |                                     | 6 □Other (Spec                 | fy)  |
| n c                        | ing P  | ü                | 27. Manner of Death 1 Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day Year)                         | 28b. Time of<br>Injury | 28c. Injury at<br>Work?   | 280          | d. Describe how in                  | njury occurred                 |  |
| isio                       | Attending r death. ector: After by the fune  | icat             | 2 Accident investigatio 3 Suicide 6 Could not b   |  |                        | M 1 Yes 2 N   |              |                                     |                                |  |
| Ď                          | ofter<br>Direction by  | Certification:   | 4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Speci             | fy)                    | factory, office   | 281          | City or Town, St                    | and Number or Rui<br>ate)      | al Route Number,                                   |
|                            | To the Hospital or Attending I within 24 hours effer death. To the Funerel Director: After completely filled in by the funer |                  | 29a. Certifier 1☐ Certifying Pf   | ysician: To the best of my kn                                    | owledge, death oc      | curred at the time, date and  | place, and   | due to the cause                    | (s) and manner as              | stated.  |
|                            | To the Hi  | ledicai          | one) A medical Exam   | niner: On the basis of examination and manner stated.            | ation and/or invest    | gation, in my opinion, deati  | h occurred   | at the time, date a                 | and place, and due             | o the cause(s)                                     |
|                            | o T with   | Σ                | 29b. Signature and title of certifier   | 1 - 0 11   | 0                      | 29c. License number   |              |                                     | Date signed (Month,            |  |
| •                          | ~  | -                | Jostos  | Jef M  | ט                      | O.C.M.E.  |              | DEC                                 | EMBER 25,                      | 2005   |
|                            | Ü  |                  | 30. Name and address of person who Tash a Z Green   |  |                        | 0<br><b>11</b> PENN STRE  | ET BA        | LTIMORE                             | MARYT, AND                     | 21201  |
|                            | Sta  | e                | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sign   | ature                  |   |              |                                     |                                |  |
|                            | Registra   | ar .             | DEC 3 o   | 2005   | k k                    |   |              |                                     |                                |  |

|                |  |                | For State Registrar   | State of Marylan   |                                  | artmen<br>rtificat        |                            |                              | nd Me               |                                       | iene  | 5                   | 42171  |
|----------------|--|----------------|---|--|----------------------------------|---------------------------|----------------------------|------------------------------|---------------------|---------------------------------------|---|---------------------|--|
|                | Physicia   | an             | 1. Decedent's Name (First, Middle, Las  | Lillie V   | . Goeg                           | el                        |                            |                              |                     | 2. Date of Death Month Decembe:       | Day   | Year                | 3. Time of Death 3:40 P M                          |
|                | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give   |  |                                  | 4b. City.                 |                            | Location of                  | Death               | Decembe.                              | 4c. County                                  | of Death            |  |
|                |  |                | 7302 Berkshire  5. Social Security Number 6. S  |  | last birthdav)                   | If Under                  | 1 Year                     | Indalk<br>If Under 24        |                     | 8. Date of Birth                      |   |                     | place (State or Foreign                            |
|                | Funeral<br>Director  |                |   | □M 2対F 88  | Yrs.                             | Months                    | Days                       | Hours                        | Min.                | (Month, Day,                          | ,1917                                       | Cou                 | ryland   |
|                | P.   |                | Usuel Residence of Decedent   |  |                                  |                           |                            |                              |                     |                                       |   |                     |  |
|                | arylar<br>ahow   | _              | 10a. State 10b. County  | 10c. Cit   | ty, Town or Lo                   | ocation                   |                            |                              |                     |                                       |   |                     | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No             |
|                | Ba-f   | Director       | Maryland Ba   | ltimore  |                                  | 101.7                     |                            | Dunda                        | 1k                  | 1/                                    | 3= Chi=== -41                               | Wh - 4 O -          |  |
|                | a or 2   | ä              |   | 3  |                                  | 10f. Zip                  | Code                       | 212                          | 22                  |                                       | og. Citizen of N<br>United                  |                     |  |
|                | ns 23  | Funeral        | 8037 Wallace R  | Oad<br>12. Was Decedent Ever in U  | .S. 13.                          | Was Dece                  | dent of Hi                 |                              |                     | cify Yes or No-                       |   |                     | ican Indian.                                       |
| 20             | J within 72 hours after death with the Maryland<br>jiene.<br>Ite M. Jical Examiner must be notified a                      | by Fun         | 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced  | Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:                               |                                  | If Yes, spe<br>1 ☐ Yes    |                            | Specify:                     | Puèrto P            | cify Yes or No-<br>Rican, etc.)       | Specify                                     | ck, White           | , etc.<br>White                                    |
| 3-003p         | 2 hou  | ed             | 15. Decedent's Ed   | ducation   | 16a. Dece                        | dent's Usu                | al Occupa                  | ition                        |                     | 1                                     | 16b. Kind of B                              |                     |  |
| 2              | within 72<br>lene.<br>than "nai  | Completed      | (Specify only highest gra   | de completed)  College (1-4or 5+)  | (Give                            | kind of wo<br>DO NOT u    | nk done a<br>se retired    | luring most o                | of workin           | g                                     |   |                     |  |
| 7              | giene<br>er tha  | mo:            | 12 Years  | 5010g5 (1 401 51)  | Hon                              | nemak                     | er                         |                              |                     |                                       | Own !                                       | Home                |  |
| 2              | be filed<br>stal Hygir<br>od other<br>event, il  | Be (           | 17. Father's Name (First, Middle, Last)   |  |                                  |                           |                            |                              |                     | (First, Middle, N                     |   | 70)                 |  |
| yland          | Ment<br>Ment<br>arke   | ၉              | Horace Gosnell  |  |                                  |                           |                            |                              |                     | Perrin                                |   |                     |  |
| Mar            | es 1 and 2 should be<br>of Health and Menta<br>I Item 27 is marked<br>r other traumatic e                                  |                | 19a. Informant's Name/Relationship (<br>Deborah Shoemak   | Type, Print)<br>er (Daughter)  | 19b. Mailii<br>7302              | ng Address<br>Berk        | s (Street a                | nd Number<br>e Road          | or Rural<br>d B     | Aoute Number.<br>altimore             | City or Town,<br>e, Mary                    | State, Zi<br>Zland  | 1 21224  |
| altimore       | Pages 1 and of He out. If Item ury or oth  |                | 20a. Method of Disposition  **X**X**Burial 2 Cremation 3 C  **4 Dogation 5 Dother (Specification 1)         | Removal from State   | Place of Disponentery, crea      | matory or o               | other place                |                              |                     | 12/28/20                              | 20c. Location -                             |                     |  |
| Dalti          | permit. Pages<br>Department of<br>Important: If it<br>any injury or o  |                | 21. Signature of Friedal Service   Son  | Entitle  | / B                              | uda-1                     | Ruckes<br>Ruckes           | fuffelya                     | al H                | ome of I                              | Dundal                                      | c, Ir               |  |
| 70             | » <sup>(</sup>   |                | 23a. Part1. Enter the disease, or com shock, or heart failure. List only                                    | plications that caused the deat<br>one cause on each line.                             | h. Do not ent                    | 922 V<br>ter the mod      | Vise<br>de of dying        | AVe.                         | ardiac or           | dalk, Ma                              | st,   | 2 2 3               | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician  |                | Immediate Cause (Final disease or condition resulting in death)   | a. Pneumonia   |                                  |                           |                            |                              |                     |                                       |   |                     | Week   |
|                | /Medical<br>Examiner   |                | resoluting in death,  | Due to (or as e conseq   | ,                                |                           |                            |                              |                     |                                       |   |                     |  |
|                | 2  | P.             | Sequentially list conditions, if any, leading to immediate  | b. End Stage   |                                  | tia A                     | Izhe                       | imer T                       | Гуре                |                                       |   |                     | Yrs.   |
|                | nted<br>Insit  | Examiner       | Sequential / list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Hypertens  | ion                              |                           |                            |                              |                     |                                       |   |                     |  |
| 'n             | exection and ital-tra  | Еха            | that initiated events<br>resulting in death) Last   | Due to (or as a conseq   |                                  |                           |                            |                              |                     |                                       |   |                     | YYS.   |
| 8/e0           | death certificate be executed<br>e attending physician and<br>ad for use as the burial-transit                             | dicai          |   | d  |                                  |                           |                            |                              |                     |                                       |   |                     |  |
| Õ              | e as t   | Med            | IF FEMALE:  |  |                                  |                           |                            |                              |                     |                                       |   |                     |  |
| X<br>R<br>R    | eath certific<br>attending p   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregna   | ıldeath 3[                       | Ectopic p                 |                            |                              |                     |                                       |   | te of deliv<br>inth | very<br>Day Year                                   |
| o.             | he de  | ysic           | 1 □ Yes 2 □ No<br>9 □ Unknown   | 4⊡Pregnant at time of d<br>9⊡Unknown   | meath 5L                         | Other (sp                 | эөспу)                     |                              |                     |                                       |   |                     |  |
| J.             | law requires that the de<br>as been signed by the a<br>2 should be detached f  |                | Part II, Other significant conditions of  | ontributing to death but not res   | ulting in the u                  | nderlying o               | ause give                  | en in Part I.                |                     | 23e. Did tob                          | acco use cont                               | ribute to           | the cause of death?                                |
| Vital Records, | quires<br>n sigr<br>ald be   | d by           | Immobility Syndro   | ome  |                                  |                           |                            |                              |                     | 1 🗆 Ye                                | s 21 No                                     | 3 🗆 Pro             | bably 4 □Unknown                                   |
| ဝ္ပ            | s been si  | Completed      | Cachexia  |  |                                  |                           |                            |                              |                     | 24a. Was an                           | 24b. 1                                      | Were aut            | opsy findings available                            |
| ž              | hysician: The law<br>his certificate has t<br>I director, page 2 s   | mo             | Dysphagia   |  |                                  |                           |                            |                              |                     | autopsy perform                       | ned?  | death?              | ompletion of cause of<br>2 □ No                    |
| Ē              | rtifica  | 0              | 25. Was case referred to medical examiner?  |  |                                  |                           |                            | 26. Place o                  | of Death            | (Check only one                       |   |                     | Daughter's   |
|                | Physician:<br>this certific<br>ral director,   | To B           | examiner?<br>1 ☐ Yes 2 🔀 No   | Hospital: 1 ☐ Inpatient 2 ☐  | ER/Outpatier                     | n 3 D                     | OA Othe                    | er: 4 🗆 Nurs                 | sing Hom            | ne 5 🗆 Resider                        | nce 6*\(\bar{\bar{\bar{\bar{\bar{\bar{\bar{ | er (Speci           | Residence  |
| n of           | <u> −                                   </u>   | .:uo           | 27. Manner of Death 1 X Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time o<br>Injury            | f                         | 28c. Injury<br>Work        | at<br>?                      | 2                   | 8d. Describe hor                      | w injury occur                              | red                 |  |
| <u>0</u>       | Attending it death. ector: After by the funer  | cati           | 2 Accident investigation 3 Suicide 6 Could not be   |  |                                  | М                         |                            | res 2 □ No                   |                     |                                       |   |                     |  |
| DIVISION       | tai or At<br>s after d<br>ai Direct<br>ed in by  | Certification: | 4 Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Specif                                  |                                  | reet, factor              | y, office                  |                              | 2                   | 8f. Location (Str<br>City or Town,    |   | er or Rur           | ral Route Number,                                  |
|                | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu | edicai         | 29a. Certifier 1 Certifying Ph<br>(Check only 2 Medical Examone)  | ysician: To the best of my kno<br>niner: On the basis of examina<br>and manner stated. | owledge, deat<br>ation and/or in | h occurred<br>vestigation | at the time<br>i, in my of | e, date and<br>pinion, death | place, a<br>occurre | nd due to the ca<br>d at the time, da | use(s) and ma<br>ite and place,             | anner as a          | stated.<br>to the cause(s)                         |
|                | To the within 2 To the comple  | Me             | 29b. Signature and title of certifier   | 10.11  |                                  | 29                        | c. License                 | number                       |                     | 29                                    | d. Date signe                               | d (Month,           | Day, Year)   |
|                |  |                | • allen 1   | Telles,  | 2011                             |                           | D 54                       | 749                          |                     |                                       | Decem                                       | ber                 | 26, 2005   |
|                | $\mathbb{O}$   |                | 30. Name and address of person who  | completed cause of death (Iter   | п 23а) (Туре,                    | Print)                    |                            |                              |                     |                                       |   |                     |  |
|                | 1  |                | Allen Reilly, M.I   | . 4 East Roll  | ing Cr                           | oss R                     | oads                       | Balti                        | imore               | e, Maryl                              | and 2                                       | 1228                |  |
|                | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year) DEC 3 0 2   | 32/Registrar's Signa   | arone evolu                      |                           |                            |                              |                     |                                       |   |                     |  |

|                     |   |                     | 1 - For<br>State<br>Registrer  | State of Mary  | land / Dep                                     |   | nt of H                              | ealth and                            | d Mental H                               |                     | _                        | 5 1                           | 2172  |
|---------------------|---|---------------------|--|--|--|---|--------------------------------------|--------------------------------------|--|---------------------|--------------------------|-------------------------------|---|
|                     | Physic<br>/Medi   |                     | Decedent's Name (First, Middle, L     MARY   | ast)   |  |   | Gr                                   | FLLION                               | 2. Date of<br>Month<br>DECEN             | (                   | Day 24/6                 | Year                          | 3. Time of Death 04:02 M                            |
| (S. )               | Exami   |                     | 4a. Facility Name (If not institution, g.<br>JOHNS 140 PIUNS BAY   | · · · · · · · · · · · · · · · · · · ·  | ENTER  | 4b. City,                                 |                                      | Location of De                       | ath                                      |                     |                          | y of Death                    | N/A   |
|                     | Funeral<br>Director   |                     | -  | Sex 7. Age (In<br>1 ☐ M 2 ☑ F 82   | yrs. last birthday<br>Yrs.                     | /) If Under<br>Months                     | Days                                 | If Under 24 H<br>Hours M             | in. 8. Date of (Month, Aug.              | Day, Yea            |                          | 9. Birthp<br>Cour<br>Pen      | place (State or Foreign<br>ntry)<br>nsylvania       |
|                     | ne Maryland<br>8a-f ehow  | ctor                | 10a. State 10b. County  Maryland Balt  | imore  | c. City, Town or L                             | _ocation                                  |                                      | Di                                   | ındalk                                   |                     |                          | 1                             | l0d. Inside City Limits                             |
|                     | 3a or 2   | i Dire              | 10e. Street and Number<br>6922 Broening I  | Road   |  | 10f. Zip                                  | Code                                 | 21222                                | )  |                     |                          | What Cour<br>Stat             | •   |
| 980                 | be filed within 72 hours atter death with the Maryland that Hygiene. Id other than "natural", or Itema 23a or 28a-1 show event. I'm Medical Exercicus must be notified at | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Note of the status of t | 12. Was Decedent Ever<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates: | in U.S. 13                                     | Was Deced<br>If Yes, spec                 |                                      | spanic Origin?<br>n, Mexican, Pu     | (Specify Yes or<br>erto Rican, etc.)     |                     | 14. Rac                  | ce - Amend<br>ck, White,      | an Indian,  |
| 215-0               | within 72 ho<br>ene.<br>than "natu<br>he Medical  | Completed           | 15. Decedent's E<br>(Specify only highest g<br>Elementary/Secondary (0·12)   | ducation<br>rade completed)<br>College (1-4or 5+)  | 16a. Dece<br>(Giv.<br>life.                    | edent's Usua<br>e kind of wo<br>DO NOT us | al Occupa<br>rk done d<br>se retired | ition<br>uring most of v             | vorking                                  | 16b.                | Kind of B                | usiness/Ind                   |   |
| Maryland 21215-0036 | d be filed within ental Hygiene.  | Be                  | 7 Years 17. Father's Name (First, Middle, Las Acy Richard  | <i>t)</i>  |  | Litho                                     | grap                                 | 18. Mother's N                       | lame (First, Midd                        |                     |                          |                               | & Seal Co   |
|                     | permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 Is marked any injury or other traumatic evonoses.                                   | 2                   | 19a. Informant's Name/Relationship Frances Langent   |  |  |   |                                      | nd Number or                         | Rurai Route Num                          |                     |                          | State, Zip                    |   |
| Baltimore,          | Pages 1 ar  |                     | 20a. Method of Disposition  1 Surial 2 Cremation 3 [ 4 Donation 5 Other (Spec  | Triamovarinom Otale  | Ob. Place of Disp<br>cometery, cre<br>Oak Lawr |   |                                      |                                      | Date 9/2005                              |                     |                          | City or To                    | wn, State Maryland                                  |
| Balti               | permit. Departmine imports any injures  |                     | 21. Signature of pure all Service Lice   |  | 2  | 2. Name an<br>Duda – R                    | d Addres                             | s of Facility<br>Funeral             | Home o                                   | f Du                | ndal}                    | c, In                         |   |
|                     | Physician<br>/Medical   |                     | 23a. Part Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  | one cause on each line.  | death. Do not en                               | nter the mod                              | e of dying                           | , such as card                       | ac or respiratory                        | arrest,             | ,                        |                               | Approximate Interval Between Onset and Death I HOUR |
|                     | cate be executed physicien and the burial-transit   | icai Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as a con  c. Due to (or as a con   | RONARY<br>resequence of):                      | ARTC                                      | RY                                   | OISEASE                              |  |                     |                          |                               | MONTH   |
| P.O. Box 68         | eath certiti<br>ettending  <br>for use as   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ f 4 ☐ Pregnant at time 9 ☐ Unknown          | etal death 3                                   | □Ectopic pre                              |                                      |                                      |  |                     | 23d. Dat<br>Mo           | e of delive                   | ry<br>Day Year                                      |
| rds, P              | w requires that the de<br>been signed by the<br>should be detached  | ğ                   | Part II. Other significant conditions  |  | resulting in the u                             | underlying ca                             | ause give                            | n in Part I.                         |  |                     | -                        |                               | e cause of death?                                   |
| Il Records,         | icien: The law re<br>certiticete has bee<br>rector, page 2 sho  | Completed           |  |  |  |   |                                      |                                      | per                                      | is an opsy formed?  | , 5                      | Vere autoporior to comileath? | osy findings available npletion of cause of         |
| Zi Si               | sicien: Th<br>certiticete<br>irector, pag   | Be                  | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No  | Hospital:  |  | -5  | Other                                |                                      | eath Check only                          |                     |                          |                               |   |
| Division of Vital   | or Attending Physicien: Ifter death. Director: After this certition in by the funeral director, I   | ation: To           | 27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  | 28a. Date of Injury<br>(Month, Day Yea   | 2 ER/Outpatier 28b. Time of Injury             |   | Bc. Injury<br>Work                   | 4 □ Nursing<br>at<br>es 2 □ No       | Home 5 Res                               | sidence<br>how inji | 6 □Othe                  | ed ( <i>Specify</i> )         | )   |
| Divis               | tal or Attencis after death   | Certification:      | 3 Suicide 6 Could not be determined  |  | At home, farm, sti<br>ecify)                   | reet, factory,                            | , office                             |                                      | 28f. Location<br>City or To              | (Street a           | nd Numbe                 | er or Rural                   | Route Number,                                       |
|                     | To the Hospital of within 24 hours af To the Funeral Discompletely filled in  | Medical             | one)   | nysician: To the best of my<br>miner: On the basis of exam<br>and manner stated.           | knowledge, deat<br>nination and/or in          | h occurred a<br>vestigation,              | at the time<br>in my opi             | e, date and place<br>nion, death occ | ce, and due to the<br>curred at the time | e cause(s           | s) and ma<br>nd place, a | nner as sta<br>and due to     | ated.<br>the cause(s)                               |
|                     | With<br>To  | 2                   | 29b. Signature and title of certifier  Culneus Salut M   | which MEDICAL DE   | octor  | 29c.                                      | License R6                           | number<br>-S - 000                   |  |                     | _                        | 24, 2                         |   |
|                     | 10  |                     | 30. Name and address of person who ADNAN MALIK, JOHN   | completed cause of death (   | Item 23a) (Type,                               |   |                                      |                                      | ALTMORE.                                 |                     |                          |                               |   |
|                     | Sta<br>Registr  | ٠.                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Si   | gnature  | Carle                                     |                                      |                                      | ,  |                     |                          |                               |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day 26, Harold Kent Harris, Sr. December 2005 9:15 MPM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Citizens Nursing Home Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days, Year) 5. Social Security Number 9. Birthplace (State or Foreign Country) 1 Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F 217-42-9150 Feb. Director 64 1941 14, Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at ONEs. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specity: ģ 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Authority Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Plumber Frederick Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Scott David Harris Irene Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11331 Coppermine Road Woodsboro, MD 21798 Harold Harris, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Hill Cemetery Dec. 30, 2005 Woodsboro, MD 22. Name and Address of Facility Burrier-Oueen Funeral Home & Crematory, 212 W. Old Liberty Road Winfield, MD 21. Signature of Juneral Service Licenses 2 Pa.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s ock, or heart failure. List only one cause on pach line. Approximate Interval Between Immeriate Cause (Final diserse or condition resilting in death) Onset and Death **Physician** therosuler 10015 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to interioriate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an autopsy performe 1 Yes No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Medical Certification; To Under (Specify) 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident investigation 1 Tes 2 No Director: , 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after To the Hospital within 24 hours a To the Funerel I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) STREET FREDERICK 31. Date filed (Month, Day, Year) 32. Digistrar's Signature State DEC3 0 Registrar 2005

| M                   |   |                | 1 - For<br>State<br>Registrar  | State of M   | laryland / De<br><i>C</i>            | partment of Fertificate of                  | Health and<br>Death |   | iene                           | 5 L                          | 217   | 4               |
|---------------------|---|----------------|--|--|--------------------------------------|---|---------------------|---|--------------------------------|------------------------------|---|-----------------|
|                     | Physici   | an             | 1. Decedent's Name (First, Middle  | a, Last)   |                                      |   |                     | 2. Date of Death                              | h                              | Year                         | 3. Time of De                                   | eath            |
|                     | /Medi   |                | Christopher I  |  |                                      |   |                     | December                                      |                                | 2005                         | 1810  | М               |
|                     | Examir  | ier            | 4a. Facility Name (If not institution  |  |                                      |   | or Location of Deal | th  |                                | y of Death                   |   |                 |
|                     | Funeral   |                | Prince George ' 5. Social Security Number  |  | jenter<br>ge (In yrs. last birthda   | Chever1 y) If Under 1 Year                  | If Under 24 Hrs     |   |                                | e Geo                        | rge's<br>lace (State or F                       | Coreian         |
|                     | Director  |                | 217-08-5425  | 1 <b>⊠</b> M 2□F                                     | 29 Yrs.                              | Months Days                                 | Hours Min.          | Month, Day,<br>Dec 28,                        | <sup>Year)</sup> 1976          | Mary.                        | try)  | o. o.g.         |
|                     | and w   |                | Usual Residence of Decedent  10a. State 10b. County                                |  | 10c. City, Town or                   | Location                                    |                     |   |                                |                              |   | 1.1             |
|                     | Maryli<br>f eho   | ō              | Maryland Howard  | a  | Columbia                             |   |                     |   |                                |                              | 0d. tnside City t                               |                 |
|                     | 1 the 1   | Director       | 10e. Street and Number   | <u></u>  | WIGHE                                | 10f. Zip Code                               |                     | 10  | Og. Citizen of                 | What Count                   |   |                 |
|                     | th with   |                | 11211 A Avalanc  | che Way  |                                      | 2104  | 4                   |   | Unite                          |                              |   |                 |
|                     | ems .   | Funerai        | 11. Marital Status   | 12. Was Decedent<br>Armed Forces                     |                                      | B. Was Decedent of h                        | Hispanic Origin? (S | Specify Yes or No-<br>to Rican, etc.)         | 14. Ra                         | ce - America                 | an Indian,                                      |                 |
| 36                  | s afte  | by Fu          | 1 Never Married 2 XMarr<br>3 Widowed 4 Divorced                                    | If Yes, Give   |                                      | 1 ☐ Yes 21 No                               |                     | ,   | Specia                         |                              |   |                 |
| 8                   | be filed within 72 hours after death with the Maryland<br>tal Hyglene.<br>d other than "natural", or items 23e or 28e-f ehow<br>event, the Medical Examinat he notified at                            | edt            | 15. Decedent   | Year or Dates:                                       |                                      | edent's Usual Occur                         | nation              |   | 16b. Kind of B                 |                              |   |                 |
| Maryland 21215-0036 | hin 73  | Completed      | (Specify only highes<br>Elementary/Secondary (0-12)                                | st grade completed)  Coltege (1-4or                  | (Gi                                  | ve kind of work done . DO NOT use retire    | during most of wo   | rking   |                                | , doi:103.gr 11.g            | ostry   |                 |
| 7                   | ygien<br>ygien<br>yerth   | Соп            | 11   |  |                                      | Carpet In:                                  | staller             |   | Self                           | -Emplo                       | yed   |                 |
| ğ                   | be fill<br>d off  | Be             | 17. Father's Name (First, Middle,  |  |                                      |   |                     | me (First, Middle, M                          |                                | ,                            |   |                 |
| Š                   | 2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23e or 28e-f ehow aumatic event, the Medical Examinar must be notified at | ည              | William Thomas  19a. Informant's Name/Relationsl                                   |  |                                      | iling Address (Street                       | `                   | na Theresa                                    |                                |                              |   |                 |
|                     | ges 1 and 2 should<br>t of Health and Men<br>if item 27 is marks<br>or other traumatic  |                | Kimberly Ann He  |  |                                      | 1 A Avala                                   |                     |   |                                |                              |   |                 |
| ē,                  | of Health<br>of Health<br>filem 27  |                | 20a. Method of Disposition   | ,  | 20b. Place of Dis                    | position (Name of<br>rematory or other plan | ce)                 |   | Oc. Location                   |                              |   |                 |
| Ē                   | Pages<br>ment of I<br>ant: If its<br>ury or o   |                | 1   Burial 2 □ Cremation  Donation 5 □ Other (Si                                   |  |                                      | oss Cemete                                  |                     | 06 B  | rookly                         | n Parl                       | k, Mary   | rland           |
| Baltimore,          | permit. Page<br>Department of<br>Important: if<br>any injury or<br>once.  |                | 21. Signature of Funeral Service   | Licensee   |                                      | 22. Name and Addre                          |                     |   | neral E                        | Home,                        | Inc.  | 1011            |
|                     | 80559   |                | 170  | Luc  |                                      | 4107 Wilke                                  | ens Avenu           | me, Baltin                                    | nore, N                        | Maryla                       | nd 2122   | 29              |
|                     |   |                | 23a. Part1. Enter the disease, or shock, or heart failure. List                    | complications that cause<br>only one cause on each I | line.                                |   |                     |   | st,                            |                              | Approximate<br>Intervat Betwee<br>Onset and Dea |                 |
| ,                   | Physician /Medical  |                | Immediate Cause (Final disease or condition resulting in death)                    | aM   |                                      | E IN:                                       | JURIK               | 3   |                                |                              |   |                 |
|                     | Examiner  |                |  | Due to (or as  | a consequence of):                   |   |                     |   |                                |                              |   |                 |
|                     |   | her            | Sequentially list conditions, it any, leaving to immediate cause. Enter Underlying | b. Due to (or as                                     | a consequence of).                   |   |                     |   |                                | -1                           |   |                 |
|                     | cuted   | Examine        | that initiated events  | c.   |                                      |   |                     |   |                                |                              |   |                 |
| 8760,               | cate be executed<br>physician and<br>the burial-transit   | I Ex           | resulting in death) Last   | Due to (or as  | a consequence of):                   |   |                     |   |                                | -                            |   |                 |
|                     | physics the b   | dicai          |  | d  |                                      |   |                     |   |                                |                              |   |                 |
| OX C                | death certific<br>e attending p<br>ed for use as  | ician/Me       | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome                                 | of pregnancy                         |   |                     |   | 334 Da                         | te of deliver                | 300   |                 |
| . Box               | death<br>e atte   | iciai          | in the past 12 months?   | 4☐Pregnant a   |                                      | ☐ Ectopic pregnancy ☐ Other (specify) _     | /                   |   |                                |                              | y<br>Day Yea                                    | ır              |
| J.                  | at the de<br>by the a<br>tached   | Physi          | 9 Unknown  | 9□ Unknown   |                                      |   |                     |   |                                |                              |   |                 |
|                     | law requirea that the<br>as been signed by th<br>2 should be detache  | by             | Part II. Dther significant condition   | ns contributing to death b                           | but not resulting in the             | underlying cause giv                        | en in Part I.       |   |                                |                              | cause of deat                                   |                 |
| Vital Records,      | w requir<br>been si<br>should   | Completed      |  |  |                                      |   |                     | 1 🗆 Yes                                       | 2 No                           | 3 Proba                      | bly 4 □Unki                                     | nown            |
| ခ္                  | The law<br>ate has b<br>page 2 si   | mple           |  |  |                                      |   |                     | 24a. Was an autopsy                           |                                | prior to com                 | sy findings ava<br>pletion of caus              | ulable<br>se of |
| ē                   | ifcian: The<br>certificate hi<br>rector, page   | e Co           | OF Man page retarned to madical  |  |                                      |   |                     |   | □ No                           | death?                       | 2□ No   |                 |
|                     | Physician:<br>r this certific<br>rel director.  | 0 8            | 25. Was case referred to medical examiner?  √√√√ Yes 2 □ No                        | Hospital: 1 ☐ Inpatio                                | ent 2 ThR/Outpati                    | ent 3 DOA Oth                               |                     | ath <i>Check only one</i><br>lome 5 - Residen |                                |                              |   |                 |
| וס ר                | ig Phy<br>ter thi   | L:U            | 27. Manner of Death  | 28a. Date of Inju                                    | 2141                                 | of 28c. tnjur                               | y at                | 28d. Describe hov                             | v injury occur                 | red ET                       | ECTED   |                 |
| DIVISION            | or Attending PP<br>after deeth.<br>Director: After th<br>in by the funerel  | Certification; | 1 Natural 5 Pending  | ation 12/28/   | 05 174                               | 0 M 1 🗆                                     | Yes 2 No            | DRIVER  | - OF C                         | AR WI                        | TICH STR  | ,uck            |
| Ë                   | f or Attendent after deet Director:   | it i           | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi                                    | ned 286. Place of in                                 | jury - At home, farm, stc. (Specify) |   |                     | 28f. Location (Stre<br>City or Town,          | State)                         | er or Rural                  | Route Number                                    | NOUH            |
| _                   | Hospital  | Ce             | 29a. Certifier 1 ☐ Certifying  | g Physician: To the best                             | of my knowledge, do                  | MWAY  | no data and slave   | OF RUSTEZ                                     | 12, COL                        | LEGER                        | ARK, n  | 0               |
|                     | To the Hospital within 24 hours a To the Funeral I completely filled  | ledicai        | (Check only Medical Sone)  | Examiner: On the basis of                            | of examination and/or                | nvestigation, in my o                       | pinion, death occu  | rred at the time, dat                         | use(s) and ma<br>te and ptace, | anner as sta<br>and due to t | ted.<br>he cause(s)                             |                 |
|                     | To the h<br>within 24<br>To the F<br>complete   | Me             | 29b. Signature and title of certifier  | 111  |                                      | 29c. Licens                                 | e number            | 29  | d. Date signe                  | d (Month, D                  | ay, Year)                                       |                 |
|                     |   |                | 1  | Lyn  |                                      | OCI   | Æ                   | De  | ecember                        | , 29.                        | 2005  |                 |
| 4                   |   |                | 30. Name and address of person v   | mo completed cause of                                | death (Item 23a) (Type               |   | nn Straat           | . Baltimo                                     |                                |                              |   |                 |
|                     | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 3 0  |  | rar's Signature                      | media .                                     | ni Derect           | . Dareline                                    | re, ric                        | тутан                        | u 21201   |                 |
|                     |   |                |  | -000   | and the same                         |   |                     |   |                                |                              |   |                 |

|                     |   |                | 1 - For<br>State<br>Registrar   | State of Ma                              | aryland.        |                          | artmen<br>tificate                      |                       |                    |                 |                                 | giene     |  | :2175  |
|---------------------|---|----------------|---|--|-----------------|--------------------------|---|-----------------------|--------------------|-----------------|---------------------------------|-----------|--|--|
|                     | Di-   | 3              | 1. Decedent's Name (First, Middle, La   | st)                                      |                 |                          |   |                       |                    |                 | 2. Date of De                   | ath       | y Year                                 | 3. Time of Death                                 |
|                     | Physici<br>/Medic   |                | Richard Jerome He   | enry                                     |                 |                          |   |                       |                    |                 | Decemb                          | er 2      | 28, 2005                               | 10:00 A M  |
|                     | Examin  |                | 4a. Facility Name (If not institution, give   | e street and number)                     |                 |                          | 4b. City,                               | Town, or              | Location o         | of Death        |                                 | 4c.       | . County of Death                      | 1  |
|                     |   |                | 108 J Governor's (  |  |                 |                          |   | Bur                   |                    | r               |                                 |           | ne Arun                                |  |
|                     | Funeral   |                | 5. Social Security Number 6. S  | ex 7. Ag<br>XIM 2□ F                     | e (In yrs. last |                          | If Under<br>Months                      | 1 Year<br>Days        | If Under<br>Hours  | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da    | ly, Year) |  | nplace (State or Foreign untry)                  |
| - 5/5               | Director  |                | 187–20–3794 Super | 74                                       | 76              | Yrs.                     |   |                       |                    |                 | Sep 23                          | , 19      | 29 Penr                                | nsylvania  |
|                     | land<br>ow  |                | 10a. State 10b. County  |  | 10c. City, T    | own or Lo                | cation                                  |                       |                    |                 |                                 |           |  | 10d. Inside City Limits                          |
|                     | Mary<br>-feh  | ţō             | Maryland Anne Arı   | ndol                                     | G1.             | en Bu                    | rnia                                    |                       |                    |                 |                                 |           |  | 1 ☐ Yes 2X No                                    |
|                     | 28a   | Director       | 10e. Street and Number  | muei                                     | l GT            | CII DO                   | 10f. Zip                                | Code                  |                    |                 |                                 | 10g. Cit  | izen of What Co                        | untry?   |
|                     | 3a o  | 0              | 108 J Governor's  | Court                                    |                 |                          | 2                                       | 1061                  |                    |                 |                                 | Unit      | ted Stat                               | es   |
|                     | d within 72 hours after death with the Maryland<br>jiene.<br>I then "netural", or Heme 23a or 28a-f ehow<br>It a Medical Examinat must be mellied at  | Funeral        | 11. Marital Status  | 12. Was Decedent                         | Ever in U.S.    | 13. \                    | Vas Deced                               | ent of His            | spanic Ori         | gin? (Spe       | crify Yes or No<br>Rican, etc.) |           | 14. Race - Amer                        |  |
| 9                   | or ite  |                | 1 ☐ Never Married 2 Married   | Armed Forces?                            |                 | i                        |   |                       |                    | і, Риепо і      | Hican, etc.)                    |           | Black, White                           | hite   |
| 8                   | ours<br>iral',  | d by           | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:           |                 |                          | I□Yes 2                                 | ZUALINO               | Specify:           |                 |                                 |           | Specify: W                             | urce   |
| 5                   | 72 h  | Completed      | 15. Decedent's Ed<br>(Specify only highest gra  |  | 1               | 6a. Deced<br>(Give       | lent's Usua<br>kind of wor<br>DO NOT us | l Occupa<br>k done di | tion<br>uring most | t of worki      | ng                              | 16b. K    | ind of Business/I                      | ndustry  |
| 121                 | within<br>iene.<br>then   | mp             | Elementary/Secondary (0-12)   | College (1-4or 5                         |                 |                          |   | e retired)            |                    |                 |                                 |           | G. 1                                   |  |
| 22                  | filed v<br>Hygie<br>other t   |                | 12<br>17. Father's Name (First, Middle, Last)   | · · · · · · · · · · · · · · · · · · ·    |                 | Sales                    | sman                                    |                       | 19 Motho           | rte Namo        | (First, Middle,                 | Majdan    | Sales                                  |  |
| auc                 | g la b  | Be             |   |  |                 |                          |   |                       |                    |                 |                                 |           | Sumame)                                |  |
| Ž                   | should be<br>nd Menta<br>marked<br>umatic ev  | P              | Unknown 19a. Informant's Name/Relationship (  | Tune Print)                              |                 | 10h Mailin               | Addraga                                 | (Street a             | 203                | <u>`</u>        | Inknown                         |           | or Town, State, Z.                     | in Control                                       |
| Maryland 21215-0036 | d 2 sho<br>th and<br>th sum<br>traum  |                | Barbara Geil / Da   |  | 1               |                          |   |                       |                    |                 |                                 | -         | aryland                                |  |
|                     | s 1 and 2 should<br>f Heelth and Mer<br>item 27 is marke<br>other traumatic   |                | 20a. Method of Disposition  | 14311002                                 | 20b. Place      | e of Dispo               | sition (Nam                             | ne of                 |                    |                 | ate                             |           | ocation - City or 1                    |  |
| no                  | 0 0   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Departion 5 ☐ Other (Specification 5 ☐ Other (Specification )  | Removal from State                       |                 |                          | natory or of                            |                       | 1                  | 1/2/2           | 2006                            |           |  |  |
| Baltimore,          | 글 문란를 .   |                | 21. Signature of Funeral Service Licer  |  | Bay             | 71eW                     | Crema                                   | COLY<br>d Address     |                    |                 |                                 | ват       | timore,                                | Maryland   |
| Ba                  | Depermination of the contract |                | 1) Kill   | Lund                                     | _               | 11                       | 107 147-                                | llkor                 | ος λτε             | Hub             | oard ru<br>Palti                | more      | al Home,                               | and 21229  |
| -                   |   |                | 23a. Part1. Enter the disease, or com   | plications that caused                   | the death. [    |                          |   |                       |                    |                 |                                 |           | e, Maryi                               | Approximate                                      |
| - 19                | Physician   |                | shock, or heart failure. List only immediate Cause (Final   | one cause on each lir                    | ne.             | 100                      | Λ                                       |                       |                    |                 |                                 |           |  | Interval Between<br>Onset and Death              |
| 1                   | /Medical  |                | disease or condition resulting in death)  | a. Due to (or as                         | a consequen     | +M1                      | M                                       |                       |                    |                 |                                 |           |  | 6 YEARS  |
|                     | Examiner  |                |   |  | (               | /-                       |   |                       |                    |                 |                                 |           |  |  |
|                     |   | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as                            | a consequen     | ce of):                  |   |                       |                    |                 |                                 |           |  |  |
|                     | be executed<br>sicien and<br>burial-transit   | Examiner       | that initiated events   | C  |                 |                          |   |                       |                    |                 |                                 |           |  |  |
| Ó                   | e be exe<br>rsicien ar<br>e burial-t  | EX             | resulting in death) Last  | Due to (or as                            | a consequen     | ce of):                  |   |                       |                    |                 |                                 |           |  |  |
| 8760,               | ¥ ≥ 64  | edical         | (   | d  |                 |                          |   |                       |                    |                 |                                 |           |  |  |
| 9                   | feath certifica<br>attending ph<br>for use as t   | Mec            | IF FEMALE:  |  |                 |                          |   |                       |                    |                 | <u>.</u>                        |           |  |  |
| Вох                 | ath ce<br>ttend<br>or us  | an/            | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome<br>1☐Live birth     |                 |                          | Ectopic pre                             | egnancy               |                    |                 |                                 | 1         | 23d. Date of delive<br>Month           | •  |
| 0.                  | of the dea<br>by the a<br>tached for  | Physician/M    | 1 Yes 2 No<br>9 Unknown   | 4□Pregnant at<br>9□Unknown               | time of death   | n 5□                     | Other (spe                              | ecify)                |                    |                 |                                 |           | WORKS                                  | Day Year   |
| Ρ.                  | thet thed by  |                | Part II. Other significant conditions c   | ontributing to death by                  | ut not recultin | a in the us              | dorbing or                              |                       | n in Dart I        |                 | 220 Didte                       | abassa u  | an anatributa ta                       | the cause of death?                              |
| of Vital Records,   | se ge   | d by           | 1 21(1). 04101 0131110211 001011010   | onting to death b                        | at not resultin | ig in the di             | idenying ca                             | iuse givei            | II HI FAILI.       |                 |                                 | res 2     |  |  |
| Ö                   | w requir<br>been si<br>should   | Completed      |   |  |                 |                          |   |                       |                    |                 |                                 |           |  |  |
| <b>3ec</b>          | E S C   | ш              |   |  |                 |                          |   |                       |                    |                 | 24a. Was<br>autop               |           | 24b. Were aut<br>prior to co<br>death? | opsy findings available<br>ompletion of cause of |
| al                  |   |                |   |  |                 |                          |   |                       |                    |                 | 1 ☐ Yes                         | 2 No      |  | 2□ No  |
| V.                  | Physicien: 1<br>this certifice<br>al director, p  | Be             | 25. Was case referred to medical examiner?  | Hospital:                                |                 |                          |   | 1                     |                    |                 | (Check only o                   |           |  |  |
| ot                  |   | <u>구</u>       | 1 ☐ Yes 2 ☐ Mo<br>27. Manner of Death   | 1 ☐ Inpatie                              | ent 2 ER/       | Outpatient<br>b. Time of |   |                       | 4 🗆 IAUI           |                 | ne 5 Resid                      |           | 6 □Other (Speci                        | <i>fy</i> )                                      |
| Ö                   | ding Ph<br>h.<br>After th<br>funeral  | Ĕ              | 1 Natural 5 ☐ Pending   | (Month, Day                              | y Year)         | Injury                   | м                                       | Bc. Injury<br>Work?   | es 2 □ N           |                 | .ou. Describe i                 | iow inqui | y occurred                             |  |
| Division            | I or Attending<br>after death.<br>Director: After<br>in by the fune   | fica           | 3 Suicide 6 Could not be  |  | urv - At home   | farm, stre               |   |                       |                    |                 | 28f Location (5                 | Street an | d Number or Bur                        | al Route Number,                                 |
| <u>S</u>            | in Dist   | Certification: | 4 Homicide  | building, etc                            | c. (Specify)    | ,,                       | ot, idotory                             | , dilloc              |                    |                 | City or Tox                     | vn, State | )                                      | arriodio rumber,                                 |
|                     | Hospital 24 hours a Funeral C   |                | 29a. Certifier 12 Certifying Ph   | ysician: To the best                     | of my knowled   | dge, death               | occurred a                              | at the time           | e, date and        | d place, a      | nd due to the                   | cause(s)  | and manner as                          | stated.  |
|                     | 24 24 B F B B B   | edical         | (Check only 2 Medical Examone)  | niner: On the basis of<br>and manner sta | examination     | and/or inv               | estigation,                             | in my opi             | inion, deat        | th occurre      | d at the time,                  | date and  | place, and due t                       | o the cause(s)                                   |
|                     | To the within 2 To the complet  | ž              | 29b. Signature and title of certifier   |  | -               |                          | 29c.                                    | License               | number             |                 |                                 | 29d. Dat  | te signed (Month,                      | Day, Year)                                       |
|                     | /   |                | > Xalalata  | M.D.                                     |                 |                          |   | Do                    | 104                | 001             | 9 1                             | )ECE      | mber De                                | 1, 2005  |
| 0                   | 117   |                | 30. Name and address of person who  | completed cause of d                     | eath (Item 23   | a) (Type, I              | Print)                                  |                       | 4 7 1              | 10              | 072016.14                       | 1.12      | mO S                                   | 11328  |
| 0                   | ,   |                | SCOTT POULTON   | J, 405 FF                                | REDer           | ich                      | 140,                                    | SUIT                  | E 90,              | 7,4             |                                 |           | 1                                      | Day, Year)  3, 2005  31, 338                     |
|                     | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 3 0   | 2005 32. Registra                        | ar's Signature  |                          | coste                                   |                       |                    |                 |                                 |           |  | 1,000 6,000 400 400                              |

|               |  |  | 1- For State of Maryland Registrar   | / Depa                                    |   | lealth an                  |  | -  | 42176   |  |  |  |
|---------------|--|--|--|---|---|----------------------------|--|--|---|--|--|--|
|               | Physici<br>/Medic  | cal  | Decedent's Name (First, Middle, Last)     LESLIE ANN HOLLIDAY  4a. Facility Name (If not institution, give street and number)  |   | 4h Cihi Tour  | L continue of D            | 2. Date of Dea<br>Month<br>Decembe                   | er 21, 200                                 | 5 12:19 P <sup>M</sup>  |  |  |  |
|               | Examir<br>Funeral<br>Director  | ier  | 1319 M* Ladies Court  5. Social Security Number 6. Sex 7. Age (In yrs. las 220-11-3164 34  | st <i>birthday)</i><br>Yrs.               | 4b. City, Town, o Pikesvi If Under 1 Year Months Days   | le<br>If Under 24          |  |  |   |  |  |  |
|               | vith the Maryland or 28a-f ahow  | Director   | Usual Residence of Decedent  10a. State 10b. County 10c. City, 1  MARYLAND HARFORD CO  10e. Street and Number  | Town or Lo                                |   |                            |  | l0g. Citizen of What (                     | 10d. Inside City Limits 1 □ Yes ¾XNo Country?                           |  |  |  |
| 000           | iled within 72 hours after death with the Maryland<br>Hydione.<br>Start than "natural", or flama 23a or 28a-f ahow<br>ant, the Maulcal Examiner must be notified at  | by Funeral   | 305 BRITTANY DR.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:   | 1   | 210<br>Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No                               |                            | ? (Specify Yes or No-<br>uerto Rican, etc.)          | U.S.A.  14. Race - An Black, Wt            |   |  |  |  |
| 7-C1717       | iiled within 72 h<br>Hygiene.<br>ther then "netu<br>nt, the Medical  | Completed  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12th grade 2yrs  17. Father's Name (First, Middle, Last)  | (Give<br>life. L                          | dent's Usual Occup<br>kind of work done<br>DO NOT use retired                                   | during most of<br>I)<br>ER | working Name (First, Middle,                         | BALTO CIT                                  | ,   |  |  |  |
| al ylali      | should be<br>and Mental<br>a marked<br>aumatic av  | To Be  | CYRIL JOHNSON  19a. Informant's Name/Relationship (Type, Print)  |   |   | BERNI<br>and Number of     | CE PAYNE r Rural Route Number                        | r, City or Town, State,                    |   |  |  |  |
| Dalilliore, I | permit. Pages 1 and 2<br>Depertment of Heelth<br>Important: if Itam 27 I<br>any injury or other tra<br>ance.   |  | 1X Burial 2 □ Cremation 3 □ Removal from State   Cem   | ce of Disponetery, crem<br>COPAL<br>RESUR | sition (Name of<br>natory or other place<br>CHURCH (<br>RECTION<br>Name and Addres<br>I C BROWN | DF 12                      | 2-29-05  | 20c. Location - City of TOPPA, MAR         | YLAND RFORD, P.A.   |  |  |  |
|               | hysician<br>/Medical<br>Examiner   |  | a. Part. Enter the disease, or complications that caused the death. Is shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequent   | Do not ente                               | ZI S PHI  | LADELPH<br>g, such as car  | ITY RTAD.'   | ABERDLEN,                                  | MD. 21001  Approximate Interval Between Onset and Death                 |  |  |  |
| ,00           | be executed cien and ourial-transit  | dical Examiner   | Sequentially list conditions, and any, leading to transport to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the conse |   |   |                            |  |  |   |  |  |  |
| .O. DOY       | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours effer death. within 24 hours effer death. the funeral Director: After this certificate has been signed by the ettending physis completely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director, page 2 should be detached for use as the tompletely filled in by the funeral director. | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 Unknown  23c. If yes, oulcome of pregnancy 1 □ Live birth 2 □ Festal de 4 □ Pregnant at time of deati  | eath 3                                    | Ectopic pregnancy Other (specify)   |                            |  | 23d. Date of do<br>Month                   | elivery<br>Day Year   |  |  |  |
| colds, r      | aw requires tha<br>s been signed<br>2 should be de   | Completed by P   | Part II. Other significant conditions contributing to death but not resulting  | ng in the ur                              | nderlying cause give  | en in Part I.              | 1 □ Y  | es 2 No 3 F                                | to the cause of death?  Probably 42/Unknown  autopsy findings available |  |  |  |
| אוומו וומ     | ician: The la<br>sertificate he<br>actor, page 2   | Be   | 25. Was case referred to medical examiner?   |   |   |                            | autops<br>perform<br>1X Yes<br>Death   Check only on | ry prior to<br>ned? death?<br>2 ☐ No 1 X e | completion of cause of  |  |  |  |
|               | To the Hospital or Attending Physician: The law fequir within 24 hours alter death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should   | Pospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Scene  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined  28a. Date of Injury 28b. Time of Injury Work?  Found (Month, Day Year) 1 Yes 2 No Subject 8 Describe how injury occurred  28b. Direct 8 Direct 8 Describe how injury occurred  28c. Injury at Work? 1 Yes 2 No Subject 8 Describe how injury occurred  28d. Describe how i |  |   |   |                            |  |  |   |  |  |  |
| 5             | Hospital or 4<br>4 hours efter<br>Funeral Dire<br>ely filled in b  |  | 29a. Certifier  (Check only  2 Madical Examiner: On the basis of examination   | Yesid                                     | Concerned at the time   | e, date and pl             | P. Kesull  | May la                                     | Ladies Court  |  |  |  |
|               | To the P<br>within 2<br>To the P<br>complete   | Medical  | one) and manner stated.  29b. Signature and title of certifier   |   | 29c. License  |                            | 2  | 9d. Date signed (Mor                       | nth, Day, Year)   |  |  |  |
|               | 5  |  | 30. Name and address of person who completed ca. If death litem 23 THE ON A TEMBERS  | 3a) (Type, I                              |   | Ctrocs                     |  | ecember 22                                 |   |  |  |  |
|               | Sta<br>Registr   |  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | from                                      | iii reiii   | priee                      | t, Baltimo   | ie, maryia                                 | II. 21201   |  |  |  |

| 1 - State<br>Registrar   |  | land / Depa<br>Ce  | rtificate of   |   | Re  | G. No.   | 42177  |
|--|--|--|--|---|---|--|--|
| 1. Decedent's Name (First, Middle, Las<br>Christopher Ray I  | •  |  |  |   | 2. Date of Death<br>Month   | Day Year   | 3. Time of Death 9:19 a. M   |
| 4a. Facility Name (If not institution, give  | street and number)   |  |  | or Location of Death  | Decembe   | 4c. County of Dea  | th   |
|  |  | some faced blight do 1   |  | If Under 24 Hze   |   |  |  |
|  | , ,  | Yrs. last birthday)<br>Yrs.  |  | Hours Min.  | Month, Day,   | 79ar)<br>,1984 Mar   | thplace (State or Foreign<br>ountry)<br>Yland  |
|  |  | _  |  |   |   |  | 10d. Inside City Limits 1 ☐ Yes 2X No  |
|  | 7  |  |  | 21  | 10  |  | ountry?  |
| 11. Marital Status   | 12. Was Decedent Ever  | in U.S. 13.  |  |   | offy Yes or No-   |  | erican Indian.   |
| 1⊠ Never Married 2 Married<br>3 Widowed 4 Divorced   | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:   |  |  |   | lican, etc.)  | Specify:   | hite   |
| (Specify only highest grade<br>Elementary/Secondary (0-12)   |  | (Give<br>life.   | kind of work done<br>DD NOT use retire   | during most of working  | g   |  | /Industry  |
| 17. Father's Name (First, Middle, Last)  |  | Mecn   | anic   | 18. Mother's Name   |   |  |  |
| Robert Eugene How  | ley  |  |  | 141-251   |   |  |  |
|  |  |  |  |   |   |  |  |
| 20a. Method of Disposition   |  |  |  |   |   |  |  |
|  |  |  |  |   |   |  |  |
| 21. Signatura of Funeral Sunnos Licens   |  | 22   | . Name and Addre   | ess of Facility<br>Cuzdzinski   | Funeral   | Home, P.   | Α.   |
| 23a. Part 1 Enter the disease, or composing shock, or heart failure. List only of  | lications that caused the cone cause on each line.   |  |  |   |   |  | Approximate<br>Interval Between  |
| Immediate Cause (Final disease of condition  | a. Narcotic Int  | oxication  |  |   |   |  | Onset and Death  |
| resulting in dea(ii)   | Due to (or as a con  | sequence of):  |  |   |   |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | b. Due to (or as a con   | sequence of):  |  |   |   |  |  |
| triat initiated events   | c  |  | <u>-</u>   |   |   |  |  |
|  | d.   | sequence of):  |  |   |   |  |  |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 1 Live birth 2 1   | Fetal death 3 [  |  | 1   |   | 23d. Date of del<br>Month  | ivery<br>Day Year  |
| Part II. Other significant conditions co<br>Cocaine Intoxication   | ntributing to death but not  | resulting in the ur  | iderlying cause giv  | en in Part I.   |   |  |  |
|  |  |  |  | <del></del>   |   |  |  |
|  |  |  |  |   | autopsy<br>performe   | ed?   death?   | topsy findings available<br>completion of cause of   |
| 25. Was case referred to medical examiner?   |  |  |  | 26. Place of Death (  |   |  | 2 🗆 No   |
|  |  | 2 ER/Outpatient  |  | 4 Livursing Home  |   |  | afy) At scene  |
| 12 Yes 2 □ No  |  | r) Find Injury   | 28c. Injur<br>Wor  | V OCTONI-   | d. Describe how   | injury occurred  |  |
| 12√ Yes 2 No  27. Manner of Death 1 Natural 5 Pending  | Fnd Month, Day Yea 12/28/05  |  | M   1 🗀  |   |   |  |  |
| 12€ Yes 2 □ No  27. Manner of Death 1 □ Natural 5 □ Pending  | 12/28/05   | 9:10 A   |  | Yes 2 XNo und   |   | et and Number or Ru<br>State) <b>Q45 Wo</b>  | ral Route Number,  |
| 27. Manner of Death  1 Natural 5 Pending 2 Accident 3 Suicide 4 Homicide  5 Could not be determined  | 12/28/05  28e. Place of Injury - A building, etc. (Sp  Found at home   | 9:10 A At home, farm, stre   | eet, factory, office   | 28  | f Location (Stre<br>City or Town,<br>Essex, M   | $\frac{State}{}$ 945 Woo<br>)  | xdlyn Rd   |
| 27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a, Certifier  1 Cartifying Physical Cartifying Physical Cartifying Cartifying Physical Cartifying Ph | 12/28/05<br>28e. Place of Injury - A<br>building, etc. (Sp   | 9:10 A At home, farm, streecify)   | eet, factory, office   | 28  | f. Location (Stre<br>City or Town,<br>Essex, M  | State) 945 Woo   | xllyn Rd   |
| 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only)  2 No  5 Pending investigation 6 Could not be determined  | 12/28/05  28e. Place of Injury - Abuilding, etc. (Sp. Found at homesician: To the best of my iner. On the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of  | 9:10 A At home, farm, streecify)   | occurred at the tinestigation, in my o   | 28 ne, date and place, an pinion, death occurred  | ff. Location (Stre<br>City or Town,<br>Essex, M<br>d due to the cau<br>lat the time, date   | State) 945 Woo<br>se(s) and manner as<br>a and place, and due  | stated. to the cause(s)  |
| 27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  | 12/28/05 28e. Place of Injury of building, etc. (Sp. Found at homer: On the best of examinant manner stated.)  | 9:10 A At home, farm, stre ecity) e knowledge, death nination and/or inv | occurred at the time estigation, in my o   | ne, date and place, an  | f Location (Stre<br>City or Town,<br>Essex, M<br>d due to the cau<br>l at the time, date  | se(s) and manner as e and place, and due  Date signed (Mont)  Comber 29  | stated. to the cause(s)  |
|  | 4a. Facility Name (If not institution, give 945 Woodlynn Road 5. Social Security Number 6. St 217-17-8815  Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon 10e. Street and Number 945 Woodlynn Road 11. Marital Status 1½ Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest grate Elementary/Secondary (0-12) 12  17. Father's Name (First, Middle, Last) Robert Eugene How 19a. Informant's Name/Relationship (7 Robert Howley (Fat Donation 5 Other (Specify 21. Signatura 2 December 12. Signatura 2 December 12. Signatura 3 December 12. Signatura 3 December 12. Signatura 3 December 13. Signatura 3 December 13. Signatura 3 December 14. Signatura 3 December 15. Signatura 3 De | Usual Residence of Decedent   10a. State   10b. County   10c             | 4a. Facility Name (If not institution, give street and number) 945 Woodlynn Road  5. Social Security Number 217–17–8815  USUM 2 F 21 Yrs.  121 Yrs.  132 Name (If not institution, give street and number) 217–17–8815  USUM 2 F 21 Yrs.  143 Name (If yes, Care)  144 Name (If yes, Care)  155 Never Married 2 Married 3 Married 3 Midowed 4 Divorced  156 Never Married 2 Married 3 Married 3 Midowed 4 Divorced  157 Never Married 2 Married 3 Married 3 Midowed 4 Divorced  158 Never Married 2 Married 3 Married 3 Midowed 4 Divorced 15 Never Married 2 Married 3 Midowed 4 Middle, Last)  159 Never Married 2 Married 15 Never Married 2 Married 15 Never Married 2 Married 15 Never Married 2 Married 16 Never Year or Dates:  150 Never Married 2 Married 17 Never Married 2 Married 17 Never Married 2 Married 17 Never Married 2 Married 18 Never Ordets 19 Never Married 2 Married 19 Never Married 19 Never Married 19 Never Married 19 Never Married 19 Never Married 19 Never Married 2 | 4a. Facility Name (If not institution, give street and number) 945 WoodLynn Road  5. Social Security Number 217-17-8815  Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore  10c. City, Town or Location  ESSEX  10d. Street and Number 945 WoodLynn Road  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of If Yes, Specify Cutter (Specify) 1945 Woodlynn Road  11. Marital Status 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Education 15. Decedents Usual Occurrents 16. Decedents Usual Occurrents 17. Father's Name (First, Middle, Last) 18. Mailing Address (Street Mechanic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street Mechanic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street Mechanic 19d. Marity Secondary (C-12) 20a. Method of Disposition 1 | 4a. Facility Name (if not institution, give street and number)  945 Woodlynn Road  5. Social Security Number 217-17-8815  Usual Residence of Decedent  10a. State 10b. County Maryland Baltimore  10b. County Maryland Baltimore  10c. City, Town or Location  Essex  10b. State 10b. County Maryland Baltimore  10c. Street and Number 945 Woodlynn Road  11. Marital Status 11. Marital Status 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify) 13. Was Decedent of Hispanic Origin? (Specify) 14. Part of Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Education (Specify only highest grade completed) 17. Pather's Name (First, Middle, Last) 18. Mother's Name 19. Mechanic 19. Mechanic 19. Mechanic 19. Mechanic 19. Meant of Diother (Specify) 19a. Informant's Name/Belationship (Type, Print) 19a. Method of Disposition 19. Burial 20Cremation 3 Removal from State 19. Decedent's Specify only highest grade completed in Burial 20Cremation 3 Removal from State 19. Burial 20Cremation 3 Removal from State State State State State State State State State State State State State State State State State State | Christopher Ray Howley  4s. Fasily Name (If not institution, give street and number)  945 Woodlymn Road  5. Social Security Number  217-17-8815  10. Mary 1 10. State 1 10. County  Maryland Baltimore  10c. City, Town or Location  Essex  101. Zip Code  945 Woodlynn Road  105. County  Maryland Baltimore  10c. City, Town or Location  Essex  107. Age (In yrs. last brinday)  108. State 1 10. County  Maryland Baltimore  106. City, Town or Location  Essex  107. Size 1 and Number  945 Woodlynn Road  11. Martal Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerio Rican, etc.)  11. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerio Rican, etc.)  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerio Rican, etc.)  12. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerio Rican, etc.)  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerio Rican, etc.)  14 Yes, Specify Cuban, Mexican, Puerio Rican, etc.)  15. Decedents State of Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify)  16. Developments Usual Occupation of Working If the Division of Working If the D | Christopher Ray Howley  4s. Failily Name (if not instance) by a street and number)  945 Woodlynn Road  5. Social Security Number 217-17-8815  105. County Maryland  106. County Maryland  107. Age (in yrs. last birthosy)  108. Stee 108. County Maryland  108. Stee 108. County Maryland  109. Citizen of What City Maryland |

|                            |  | •                                    | State of Maryland / Department of Health and Mental Hygiene  1 - For State Registrar  Certificate of Death  Reg. No. 0   | 5 42178   |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
|----------------------------|--|--------------------------------------|--|---|------------------|---|---|---|---|---|---|---|----|----|---|----|---|----|--|---|
|                            | Physici<br>/Medio<br>Examir  | al                                   | Au. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County or  | Year 3. Time of Death  Year / 0.50 A M  f Death         |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
|                            | Funeral<br>Director  |                                      | 5. Social Security Number 6. Sex 1 A Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. Year) 1 Yrs. Months Days Hours Min. 08 Office (Month, Day. Year) 1 Usual Residence of Decedent   | 9. Birthplace (State or Foreign<br>Country)<br>MD       |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
|                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: if item 27 is marked other then "natural", or items 23a or 28a-f show says injury or other traumatic event, it a Medical Exam and must be notified at ADGE.  | Director                             | 10a. State   | 10d. Inside City Limits 11 Yes 2 □ No                   |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| 15-0036                    |  | by Funeral                           | 717 Druid Park Lake Drive Apt 801 21217 U.S.  11. Marital Status 1 Never Married XXMarried 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes X No Specify: Specify:   | S • A • - American Indian, , White, etc. Black          |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| and 2121                   |  | Be Completed                         | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)  | Smelting Co   |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| Baltimore, Maryland        |  |                                      | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  Elizabeth Holloman—Wife  20a. Method of Disposition    Survey   Place of Disposition (Name of cermetery, crematory or other place)   Date   20c. Location - Commetery, crematory or other place)   Commetery, crematory or other place   Commetery, crematory or other place)   Commetery, crematory or other place)   Commetery, crematory or other place)   Commetery, crematory or other place)   Commetery, crematory or other place)   Commetery   Commetery   Commetery   Commetery   Commetery   Commetery   Commetery   Commetery   Commetery   Commetery   Com | Ol, Balto City or Town, State Mills, Md                 |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| 8760,                      | Sate be executed hysician and hysician and the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat-transit the buriat- | dical Examiner                       | 23a Pa . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line.  Immune the Cause (Final disease or condition read ling in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  | Approximate<br>Interval Between<br>Onset and Death      |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| .O. Box 6                  | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit   | Physician/Me                         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | ,   |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| <u>α</u>                   |  | Certification: To Be Completed by Ph | To Be Completed by   | þ   | by               | þ | þ | þ | þ | þ | þ | þ | by | by | þ | by | þ | by | Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I. 236. Did too accorded use contributing to the part II. 236. Did too accorded use contributing to the part II. 236. Did too accorded use contributing to the part II. 236. Did too accorded use contributing to the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributing the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part II. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did too accorded use contributions the part III. 236. Did t | oute to the cause of death?  B Probably 4 Unknown  ere autopsy findings available for to completion of cause of lath?  Yes 2 No |
| Division of Vital Records, |  |                                      |  | 25. Was case referred to medical examiner?  1  Yes 2 No | · (Specify)<br>d |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| _                          |  | edical                               | 29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manipulation and/or investigation, in my opinion, death occurred at the time, date and place, and manner stated.   | nd due to the cause(s)                                  |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
|                            | 0X/  | W                                    | 29b. Signature and title of certifier  Tan, M. D.  29c. License number  29d. Date signed  DECEMBER  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  AURORA C. TAN 39VN AUCH PAVEN BULLEVARD, BALTIMORE, M.D.   | (Month, Day, Year)<br>29, 2005                          |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |
| 133                        | Sta<br>Regist  |                                      | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | 21218   |                  |   |   |   |   |   |   |   |    |    |   |    |   |    |  |   |

|  |  | _               | For<br>State<br>Registrar  | State of Maryland / Depa   | artment of Health and I   | Mental Hygien   | HH5 4/1/9  |  |  |  |
|--|--|-----------------|--|--|---|---|--|--|--|--|
|  | Physici  | an              | 1. Decedent's Name (First, Middle, Last                                | ENE Harris   |   | 2. Date of Death  Month  D  | 3. Time of Death 0343 A M  |  |  |  |
|  | /Medic<br>Examin   |                 | 4a. Facility Name (If not institution, give                            | street and number)   | 4b. City, Town, or Location of Deat   | h 4   | c. County of Death   |  |  |  |
|  |  |                 | PRINCE GEORGES HOS  5. Social Security Number 6. Se                    |  | CHEVERLY  If Under 1 Year   If Under 24 Hrs   |   | RINCE GEORGES  9. Birthplace (State or Foreign                       |  |  |  |
|  | Funeral<br>Director  |                 | 577-94-1329  | XiM 2□F 31 Yrs.  | Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Year   | 74 Wash., D.C.   |  |  |  |
|  | yland  |                 | Usual Residence of Decedent  10a. State 10b. County                    | 10c. City, Town or Lo  | 1 .   |   | 10d. Inside City Limits  |  |  |  |
|  | the Mar<br>28a-f al  | Director        | MD. P. G.  | CAPITO   | L HEIGHT'S  | T   | 1 ☐ Yes 2 k No   |  |  |  |
|  | h with   | al Dir          | 5606 Coolidge  | STREET   | 20743   | 109.0   | ) SA   |  |  |  |
|  | itema i  | Funeral         | 11. Marital Status   | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No                       | Was Decedent of Hispanic Origin? (S<br>f Yes, specify Cuban, Mexican, Puer            | pecify Yes or No-<br>to Rican, etc.)  | 14. Race - American Indian,<br>Black, White, etc.                    |  |  |  |
| 21215-0036   | be filed within 72 hours after deeth with the Maryland tal Hygiene. Id other than "natural", or itema 23e or 28e-f ahow avent, the Modral Examiner must be multiled at | þ               | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced                 | If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 ☑ No Specify:   |   | specify: BLACK   |  |  |  |
| 15-0   | n natu   | To Be Completed | 15. Decedent's Ed<br>(Specify only highest grad                        | de completed) (Give  | dent's Usual Occupation<br>kind of work done during most of wo<br>DO NOT use retired) | rking 16b.  | Kind of Business/Industry  |  |  |  |
| 212  | filed withi<br>Hygiene.<br>khar than   |                 | Elementary/Secondary (0-12)  | College (1-4or 5+)   | STANT Manage  |   | UTO ZONE   |  |  |  |
| land   | d la b   |                 | 17. Father's Name (First, Middle, Last) HENTY FOW                      | ard Jennings   | 0.0   | ne (First, Middle, Maide  | ACCIS  |  |  |  |
| Maryland   | 2 sh<br>and<br>is m  |                 | 19a. Informant's Name/Relationship (T                                  | 1  | () 1  | ural Route Number, City   | or Town, State, Zip Code) 20743                                      |  |  |  |
|  | 1 an<br>Heei<br>am 2<br>thar   |                 | 20a. Method of Disposition   | 20b. Place of Dispo  |   | Date 20c. I   | Location - City or Town, State                                       |  |  |  |
| Baltimore,   | permit. Pages<br>Department of I<br>Important: If It<br>any injury or o  |                 | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify                     | Removal from State Riverdals   | L Gernatory 12/   | 30/05/14  | verdule, MD.   |  |  |  |
| Ba   | permit. Pag<br>Department<br>Important: t<br>any injury o  |                 | 21. Signature of Funeral Service Licens                                | Xux moin8  | 2. Name and Address of Facility  D. K. NENTLEH  | 420 HS  | D.C. 2000'Z  |  |  |  |
| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |                 |  |  |   |   |  |  |  |  |
|  | Physician<br>/Medical  |                 | Immediate Cause (Final disease or condition resulting in death)        | a Control of or as a consequence of):  | Hound to chest  |   |  |  |  |  |
|  | Examiner   | -e              | Sequentially list conditions, if any, leading to immediate             | b. Due to (or as a consequence of):  | tue to (or as a consequence of):  |   |  |  |  |  |
|  | sate be executed physicien and the burial-transit  | Examiner        | cause. Enter Underlying Cause (Disease or injury that initiated events | С  |   |   |  |  |  |  |
| 8760,  |  | dical Ex        | resulting in death) Last  Due to (or as a consequence of):             |  |   |   |  |  |  |  |
| 9  | ertificate<br>ling physi<br>e as the t   | Medic           | IF FEMALE:   | •  |   |   |  |  |  |  |
| Box .  | The law requires thet the death certific ste hes been signed by the attending page 2 should be detached for use as   | Physician/Me    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No       | 4 Pregnant at time of death 5 □  | Ectopic pregnancy Other (specify)   |   | 23d. Date of delivery  Month Day Year                                |  |  |  |
| P.O.   | thet the de<br>ed by the<br>detached   | Phys            | 9 Unknown  | 9□ Unknown  ontributing to death but not resulting in the u                            | ndarkving causa gwen in Part I  | 23e Did tobacco   | use contribute to the cause of death?                                |  |  |  |
|  | quires the   | ed by           | Takin. Other significant conditions of                                 | orthoday to death out not resuming in the d  | nderlying cause given in r arci.  |   | 2 No 3 Probably 4 Unknown  |  |  |  |
| of Vital Records,  | e law requ<br>hes been<br>je 2 shouli  | Completed by    |  |  |   | 24a. Was an autopsy   | 24b. Were autopsy findings available prior to completion of cause of |  |  |  |
| tal F  |  | 0               | 25. Was case referred to medical                                       |  | 26 Place of De  | performed?  1 Yes 2 XN  ath Check only one                                      | death?   |  |  |  |
| Ϋ́   | \$ e 5   | 10 B            | IX 162 5 140   | Hospital: 1 Inpatient 2 ER/Outpatier   | nt 30 DOA Other: 4 Nursing H  | lome 5 ☐ Residence  |  |  |  |  |
|  | fe fe  | tlon:           | 27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury<br>(Month, Day Year) 28b. Time o<br>Injury                         | 28c. Injury at Work?  1 Yes 2 No  | Suh wat s   | hot set  |  |  |  |
| Division   | or Attar<br>fler dea<br>iractor<br>n by the  | Certification;  | 3 Suicide 6 ☐ Could not be determined                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28t. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |
|  | To the Hospital or Attending within 24 hours efter death.  To the Funerel Director: After completely filled in by the fune   |                 |  |  |   |   |  |  |  |  |
|  | the Ho<br>the Fu<br>The Fu   | Medical         | (Check only and title of certifier                                     | iner: On the basis of examination and/or in<br>and manner stated.                      | vestigation, in my opinion, death occu  |   | ate signed (Month, Day, Year)  |  |  |  |
|  | Z viit   |                 | Soul Signature and title of certifier                                  | yeal III   | OCME  |   | EMBER 24, 2005   |  |  |  |
|  | 18   |                 | - 1 - (  | completed cause of death (Item 23a) (Type,   |   |   | -  |  |  |  |
|  | Sta  | ate.            | 31. Date filed (Month, Day, Year)                                      | Las Registrar's Signature  | NN STREET, BALTIN   | MORE, MARYLA  | AND, 21201   |  |  |  |
|  | Regist   |                 | DEC 3 n 2005   | Alexander M. Agent   | E .   |   |  |  |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

|                   |   |                  | For State   | State of Marylar   |                                  | epartment of H<br>Certificate of L                          |  |  | ep 0 0 5                                   | 42180   |
|-------------------|---|------------------|---|--|----------------------------------|---|--|--|--|---|
| 2                 | D. Jak  |                  | Registrar  1. Decedent's Name (First, Middle, Las   | t)   |                                  | 00.10010 0. 1   |  | 2. Date of Deat                          | n  | 3. Time of Death  |
|                   | Physicia<br>/Medic  |                  | Roby Gerald Huffi   |  | Dec                              | 21 ZC   | 05 100 1 AM                                |  |  |   |
|                   | Examin  |                  | 4a. Facility Name (If not institution, give   | street and number)   | 71/                              | 4b. City, Town, or  | Location of Death                          | a 41/                                    | 4c. County of D                            | eath  |
| 2.0               |   |                  | 5. Social Security-Mumber 6. So   | TOSOIJ<br>ex 7. Age (In yrs.   | last birti                       | MOULTI  | I MOV                                      | 8. Date of Birth                         | n/a  | Birthplace (State or Foreign                            |
|                   | Funeral Director  |                  |   | M 2□F 62   |                                  | rs. Months Days   | Hours Min.                                 | Month Day,                               | 1943 Vi                                    | Country)<br>Lrginia                                     |
| ***               | Ď   |                  | Usual Residence of Decedent   | 140-0  |                                  |   |  |  |  | 101 1-11-01-11-1  |
|                   | anylar<br>show  | ۲                | MD 10b. County n/a  |  | <sub>ty, rown</sub><br>Ltim      | or Location   |  |  |  | 10d. Inside City Limits 1 AYes 2 No                     |
|                   | the M   | ecto             | 10e. Street and Number  | Da   | LCIII                            | 10f. Zip Code   |  | 10                                       | og. Citizen of What                        |   |
|                   | death with the Maryland<br>ms 23s or 28a-f show<br>Firms I ke polities at   | Funeral Director | 1928 Christian St   |  |                                  | 21223   |  | 1  | Jnited St                                  | ates  |
|                   | death   | nera             | 11. Marital Status  | 12. Was Decedent Eyer in L   | B62                              | 13. Was Decedent of Hi<br>If Yes, specify Cuba              | ispanic Origin? (Sp                        |  |  | merican Indian,   |
| 5-0036            | in 72 hours after death with the Manylar<br>n "natural", or items 23e or 28a-f show<br>tedical Exeminar must be notified at | þ                | 1 ☐ Never Married 2점 Married<br>3 ☐ Widowed 4 ☐ Divorced                                    | 1 ⊠Yes 2 □ No  | JN66                             | 1 ☐ Yes 2 ☒ No  | Specify:                                   | riioari, oto.,                           | Specify:                                   | White   |
| 2<br>C            | 72 hc<br>natu   | Completed        | 15. Decedent's Ed<br>(Specify only highest gra  |  | 16a.                             | Decedent's Usual Occupa<br>(Give kind of work done of       | during most of work                        |  | 16b. Kind of Busine                        | ss/industry   |
| 121               | with<br>the   | dmo              | Elementary/Secondary (0-12)   | College (1-4or 5+)   | We                               | life. DO NOT use retired  1der                              | ")   |  | Steel Fal                                  | orication   |
| 7                 | Hyg<br>ther<br>ther   | Be Co            | 17. Father's Name (First, Middle, Last)   |  | 1                                |   | 18. Mother's Name                          | e (First, Middle, N                      | Maiden Sumame)                             |   |
| <u> a</u>         | d as b  | ToB              | Edgar Dean Huffma   | n  |                                  |   | Sarah P                                    | enningto                                 | n  |   |
| Maryland          | 2 should<br>and Men<br>is marke   |                  | 19a. Informant's Name/Relationship (  |  |                                  | Mailing Address (Street a                                   |  |  | •  | e, Zip Code)  |
|                   | ss 1 and 2 should<br>of Health and Me<br>litem 27 is mark<br>r other traumation   |                  | Violet Huffman /  |  |                                  | 28 Christian Disposition (Name of                           |  |  | MD 21223<br>20c. Location - City           | or Tourn State  |
| Baltimore,        | Pages 1<br>nent of H<br>ant: If Ite<br>ary or ot  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐                                     | Removal from State   | cemeter                          | y, crematory or other place Park Cemet                      | e)   |  |  |   |
|                   | permit. Pages Department of I Importent: If Ite any injury or or  |                  | 4 □ Donation 5 □ Other (Specify 21. Signature of Furral Service Ligen                       |  | uuoi                             | 22. Name and Address  | - 1  |  |  | , Maryland  |
| Ba                | Depri<br>impo   |                  | WHILE A MONTH   | 1/20   |                                  |   |  |  |  | Maryland 21227  |
|                   |   |                  | 23a. Part1. Enter the disease, or compshock, or heart failure. List only                    | plications that caused the dea   | th. Do n                         |   |  |  |  | Approximate<br>Interval Between                         |
|                   | Physician   |                  | Immediate Cause (Final disease or condition   | (120) Ato.   | 7                                | xtical  | diavas                                     | scula                                    | 2022/6                                     | Onset and Death   |
|                   | /Medical<br>Examiner  | ).               | resulting in death)   | Due to (or as a conse  |                                  |   |  | ,  | - 0000                                     |   |
|                   | Lxailillei  |                  | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): |  |                                  |   |  |  |  |   |
|                   | nsit  | nlne             | Cause (Disease or injury  | Dag to (01 as a conse-   | quonce                           |   |  |  |  |   |
| Ć.                | execu<br>in and<br>ial-tra  | Examiner         | that initiated events<br>resulting in death) Last   | Due to (or as a conse  | Due to (or as a consequence of): |   |  |  |  |   |
| 58760,            | icate be executed<br>physicien and<br>s the burial-transit  | edical           | (   | d  |                                  |   |  |  |  |   |
| _                 |   | Med              | IF FEMALE:  |  |                                  |   |  |  |  |   |
| Вох               | death certifi<br>e attending<br>id for use as   | lan/Me           | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregn<br>1 Live birth 2 Fet<br>4 Pregnant at time of         | al death                         | 3 Ectopic pregnancy 5 Other (specify)                       |  |  | 23d. Date of<br>Month                      | delivery<br>Day Year                                    |
| Ö.                | 0 0   | Physic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9 Unknown  | deau:                            | 5 Cities (specily)  |  |  |  |   |
| Ω.                | The law requires that the tile has been signed by the bage 2 should be detache  | by Pl            | Part II. Other significant conditions of  | ontributing to death but not re  | sufting in                       | the underlying cause give                                   | en in Part I.                              | 23e. Did tob                             | acco use contribute                        | e to the cause of death?                                |
| ğ                 | w require<br>been sig<br>should b   | ed t             | d. chitcy   |  |                                  |   |  | 1 ☐ Ye                                   | s 2 No 3                                   | Probably 4 Unknown                                      |
| Records,          | law re<br>as be   | Completed        |   |  |                                  |   |  | 24a. Was ar<br>autops                    | y prior                                    | autopsy findings available<br>to completion of cause of |
|                   |   | Con              |   |  |                                  |   |  | perform                                  |  | 1?<br>∕es 2□ No   |
| Ĕ                 | sicien<br>certifi<br>rector   | Be               | 25. Was case referred to medicat examiner?  1 ☐ Yes 2 No                                    | Hospital:  | Zenio                            | tratical 3D DOA Othe  | 26. Place of Deat                          |  |  |   |
| ō                 | F = F   | 7: To            | 27. Manner of Death   | 28a. Date of Injury  | 28b. T                           | ime of 28c. Injury  | 4 🗀 Nursing Ho                             |  | nce 6 Other (S                             | Specify)  |
| <u></u>           | Attending F<br>death.<br>ctor: After<br>y the funer   | atlo             | Natural 5 Pending 2 Accident Investigation  |  | 11                               |   | Yes 2 □No                                  |  |  |   |
| Division of Vital | or Attencater death<br>Director:  | Certification:   | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined                                      | 28e. Place of Injury - At I<br>building, etc. (Spec                                  |                                  | rm, street, factory, office                                 |  | 28f. Location (St.<br>City or Town       |  | Rural Route Number,                                     |
|                   | urs af<br>oral D  |                  | CO. Cartillar D. Cartifaire D.  |  |                                  | 4   |  |  |  |   |
|                   | 24 hos  | edical           | 29a. Certifier Certifying Ph<br>(Unack only 2) Medical Exar                                 | ysician: To the best of my kn<br>niner: On the basis of examin<br>and manner stated. | ation an                         | , death occurred at the tin<br>Divor investigation, in my o | ne, date and place,<br>pinion, death occur | and due to the ca<br>red at the time, da | iuse(s) and manner<br>ate and place, and o | r as stated.<br>due to the cause(s)                     |
|                   | To the Hospitel or Attenwihin 24 hours after deat To the Funeral Director: completely filled in by the                      | Me               | 29b. Signature and title of certifier   |  |                                  | 29c. Licensi  | e number                                   |  | 9d. Date signed (Mo                        |   |
|                   | . 1   |                  | 1 amma 1  | andre  | M                                | D 03  | 3061                                       | 1  | )ccmb                                      | 1521,2005   |
|                   | KTI   |                  | 3) Name and address of person with  | completed cause of death (Ite  |                                  |   |  | P  | 1+   | or 21,2005  |
|                   | )   |                  | A. Date filed (Month, Day, Year)  | 32. Pegistrar's Sign   |                                  | o Coton   | MUZNE                                      | ic De                                    | and my                                     | or and  |
| 1                 | Sta<br>Regist   |                  | di mb m   | 005  | K                                | (costs)   |  |  |  |   |
|                   |   |                  |   | N. DET PROFESSION  | 100                              | a AV  |  |  |  |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Alice Brittingham Isaacs 9:00 A M 29 2005 December /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Baltimore Catonsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dev. Year) Birthplace (Stete or Foreign Country) **Funeral** Hours 1□M 2**⊠**F 219-18-8359 Director 82 31, 1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Baltimore Catonsville 1 ☐ Yes 2 🕱 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 719 Maiden Choice Lane HR 135 21228 United States or Items 23a Funeral Pages 1 and 2 should be tiled within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Is marked other ther 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry MacLeod Sarah Hoffman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a. Informant's Name/Relationship (Type, Print) nt of Health at: If Item 27 Is Alvin Tabler Isaacs / Husband 719 Maiden Choice Lane HR 135, Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. 4 Denation 5 Other (Specify) Loudon Park Cemetery | 1/3/2006 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Jignature of Funeral Service Licens 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any learning Lammada, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certiticate be executed and Due to (or as a consequence of): Box 68760 attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2/ No 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient Nursing Home 5 Residence 6 Other (Specify) 3 DOA SIUI 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Atter 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by hours after 4 Homicide Hospitel within 24 hours a 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check onh To the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30, Name and address of pers who completed cause of death (Item 23a) (Type, Print) on Chaulany 31. Date filed (Month Day, Ye 32 Registrar's Signature State 0 2005 Registrar

|                            |  |                | For State   | State of M                       | arylan       |  | artment of F                             |              |                          | -                        |           | 2005                       | 12182  |
|----------------------------|--|----------------|---|----------------------------------|--------------|--|--|--------------|--------------------------|--------------------------|-----------|----------------------------|--|
|                            |  |                | Registrar  1. Decedent's Name (First, Middle, Las                           | <i>t</i> )                       |              |  | incate of                                | Dear         | 11                       | 2. Date of De            | Reg. No   | -000                       | 3. Time of Death                                 |
|                            | Physici  | an             | MARY  |                                  |              |  | Kr                                       | 2 A1A        | 50                       | _ Month                  | Da        | h                          | -11 04   |
|                            | /Medic   |                | 4a. Facility Name (If not institution, give                                 | street and number                |              |  | 4b. City. Town, o                        | HVV          | -                        | DECEME                   |           | County of Dea              | 101.0  |
| 1                          | Examin   | er             |   |                                  |              |  | A  | VICINE       |                          |                          | 1         | . County of Dea            | idi)   |
|                            |  |                | THE JOHNS HOPKI   | 1                                | 19 (In vrs.) | last birthday)   | If Under 1 Year                          | (            | ler 24 Hrs.              | 8. Date of Bir           | th        | 9 Bir                      | thplace (State or Foreign                        |
| н                          | Funeral<br>Director  |                |   | ☐ M 2X F                         | 6            | ., ,,  | Months Days                              | Hour         |                          | (Month, Da<br>Dec. 2     | y, Year)  | C                          | ie, PA   |
|                            |  |                | Usual Residence of Decedent   |                                  |              |  |  |              |                          | DEC. Z                   | 0, 1      | 950 21-                    | 111  |
|                            | ehow   |                | 10a. State 10b. County  |                                  | 10c. City    | y, Town or Lo  | cation                                   |              |                          |                          |           |                            | 10d. Inside City Limits                          |
|                            | Mar  | ģ              | Maryland Prince G   | eorge's                          | Lau          | re1  |  |              |                          |                          |           |                            | 1 Yes 2X No                                      |
|                            | r 282  | Director       | 10e. Street and Number  |                                  |              |  | 10f. Zip Code                            |              |                          |                          | 10g. Cit  | izen of What C             | ountry?  |
|                            | h wit  | <u></u>        | 790 Laurel Lakes  | Court, #4                        | 414          |  | 20707                                    |              |                          |                          | Unit      | ed Stat                    | tes  |
|                            | death  | Funeral        | 11. Marital Status  | 12. Was Decedent<br>Armed Forces | Ever in U.   | S. 13.   | Was Decedent of I                        | dispanic     | Origin? (Spe             | city Yes or No           |           | 14. Race - Am              | erican Indian,                                   |
| 9                          | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f ehow or other traumatic event, the Modical Exaft for must be notified at | Ē              | 1 Never Married 2 Married   | 1 ☐ Yes 2 X                      |              |  | 1 Tes, specily Cub<br>1 ☐ Yes 217 No     |              |                          | nican, etc./             |           | Black, Whi                 | te, etc.   |
| 21215-0036                 | ours   | y by           | 3X Widowed 4 □ Divorced   | Year or Dates:                   |              |  | 10 163 241110                            | Spec         |                          |                          |           | Wh                         | nite   |
| 5-0                        | 72 h   | Completed      | 15. Decedent's Ed<br>(Specify only highest gra                              |                                  |              | (Give  | dent's Usual Occup<br>kind of work done  | during m     | ost of workir            | ng g                     | 16b. K    | ind of Business            | /Industry  |
| 21                         | ithi.  | du             | Elementary/Secondary (0-12)   | College (1-4or                   | 5+)          | life.  | DO NOT use retire                        | d)           |                          |                          |           |                            |  |
|                            | filed w<br>Hygier<br>other th  | ပိ             | 12  |                                  |              | Retai  | 1 Sales                                  | 40.11        |                          | /F:                      |           | 1mark (                    | Cards  |
| <u>n</u>                   | 2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the Me  | Be             | 17. Father's Name (First, Middle, Last)                                     |                                  |              |  |  |              |                          | (First, Middle           | , маюеп   | Sumame)                    |  |
| Σ                          | should<br>ind Men<br>ind marke   | 2              | John Fetzner  |                                  |              | 1  |  |              | ion Ho                   |                          |           |                            |  |
| Maryland                   | 2 sh<br>and<br>le m  | p ii           | 19a. Informant's Name/Relationship (  |                                  |              |  | ng Address (Street                       |              |                          |                          |           |                            | Zip Code)  |
|                            | of Health<br>of Health<br>litem 27   |                | Brigette Jerome/D   | aughter                          | 20h B        | The state of the s | Kings Gr                                 | ant          | The second second second | Laurel                   |           | 20/23<br>ocation - City or | Town State                                       |
| Ö                          | Pages 1<br>nent of H<br>int: If ite  |                | 1 XBurial 2 ☐ Cremation 3 ☐   | Removal from State               |              | emetery, crei  | natory or other pla                      | •            | 1 _                      |                          |           |                            |  |
| Ë                          | tmen<br>tant:  |                | 4 ☐ Donation 5 ☐ Other (Specification )                                     |                                  |              |  | Cemetery                                 |              |                          | , 2005                   | Mil       | 1creek                     | Twp., PA   |
| Baltimore,                 | permit. Pages<br>Department of<br>Important: If it<br>eny Injury or c  |                | 21. Signature of Funeral Service Licer                                      |                                  | 1110         | Br   | Name and Address Ho:                     | me f         | or Fun                   | erals                    |           |                            |  |
|                            | an i e d   | _              | nancy.  | NESSEL.                          | <u>le</u>    | / 15   | 95 West                                  | <u> 38th</u> | Stree                    | et, Eri                  |           | A 16508                    | Approximate                                      |
|                            |  | 8 8            | 23a. Part 1. Enter the disease, or com<br>shock, or head failure. List only | one cause on each I              | ine.         |  |  |              | as cardiac o             | i respiratory a          | 11651,    |                            | Interval Between<br>Onset and Death              |
|                            | Physician  |                | Immediate Cause (Final disease or condition resulting in death)             | a BURKI                          | TT           |  | MPHOMI                                   | Ą            |                          |                          |           |                            | 3 MONTHS   |
|                            | /Medical<br>Examiner   |                |   | Due to (or as                    | a consequ    | uence of):   |  |              |                          |                          |           |                            |  |
|                            |  | -              | Sequentially list conditions, if any, leading to immediate                  | b. Due to (or as                 | a consecu    | uence ofi  |  |              |                          |                          |           |                            |  |
|                            | bed<br>selt  | 를              | cause. Enter Underlying Cause (Disease or injury that initiated events      | 545 (5. 4.                       |              | 20.100 017.  |  |              |                          |                          |           |                            |  |
| •                          | xecur<br>and<br>al-trai  | Examiner       | that initiated events resulting in death) Last                              | c. Due to (or as                 | a consequ    | uence of):   |  |              |                          |                          |           |                            |  |
| 8760,                      | cate be executed<br>obysicien and<br>the burial-transit  | dical          |   |                                  |              |  |  |              |                          |                          |           |                            |  |
| 687                        | ficate<br>physics the  | ag<br>og       |   | . d.                             |              |  |  |              |                          |                          |           |                            |  |
| Box                        | requires that the death certificate be executed<br>een signed by the attending physicien and<br>hould be detached for use as the burial-transit  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant                                    | 23c. If yes, outcome             |              |  |  |              |                          |                          |           | 23d. Date of de            | elivery  |
|                            | death<br>atte  | Cla            | in the past 12 months? 1 ☐ Yes 2 🏋 No                                       | 1□Live birth<br>4□Pregnant a     |              |  | ]Ectopic pregnanc<br>] Other (specify) _ | у            |                          |                          |           | Month                      | Day Year   |
| P.O.                       | the c<br>by the  | lys            | 9 Unknown   | 9 Unknown                        |              |  |  |              |                          |                          |           |                            |  |
|                            | that   |                | Part II. Other significant conditions of                                    | ontributing to death I           | but not resi | ulting in the u  | nderlying cause giv                      | ven in Pa    | rt I.                    | 23e. Did t               | obacco    | use contribute t           | o the cause of death?                            |
| rds                        | w requires that<br>been signed to<br>should be det   | Completed by   |   |                                  |              |  |  |              |                          | 10                       | Yes 2     | □ No 3 □ P                 | robably 4 Unknown                                |
| 00                         | > D 0  | ete            |   |                                  |              |  |  |              |                          | 24a. Was                 | an        | 24b. Were a                | utopsy findings available completion of cause of |
| Re                         | The law  | E              |   |                                  |              |  | <del></del> -                            |              |                          | auto                     | rmed?     | death?                     | completion of cause of<br>s 2 No                 |
| tal                        | ilcian: Th<br>certificate<br>rector, pag   | 0              | 25. Was case referred to medical  |                                  |              |  |  | 26 PI        | ace of Death             | 1 ☐ Yes<br>(Check only o | No No     | 1 1 10                     | s 2LINO  |
| >                          | Physician:<br>this certificantal director,   | To B           | examiner?   | Hospital: 1 X Inpati             | ient 2 🗆     | ER/Outpatier   | nt 3 DOA Ott                             | nor-         |                          |                          |           | 6 □Other (Spe              | acifu)   |
| o                          | g Phy<br>er this   | 늘              | 27. Manner of Death   | 28a. Date of Inj<br>(Month, Da   |              | 28b. Time o  |  |              |                          | 28d. Describe            |           |                            | , only /   |
| jo                         | nding<br>ath.<br>r: Aft  | 읉              | 1 Natural 5 Pending<br>2 Accident investigation                             |                                  | ay rear)     | Injury   |  | Yes 2        | □No                      |                          |           |                            |  |
| Division of Vital Records, | Atte   | 5              | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined                      | 286. Place of in                 | jury - At ho | ome, farm, sti   | eet, factory, office                     |              | 2                        | 28f. Location (          | Street ar | nd Number or R             | lural Route Number,                              |
| ā                          | s after Dir  | Certification; | 4 I Homodo  | building, e                      | ic. (Specii) | "  |  |              |                          | ony or ro                | m, State  | */                         |  |
|                            | To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this occupietely filled in by the funeral director.  |                | 29a. Certifier Certifying Ph  | ysician: To the besi             | of my kno    | wledge, deat   | h occurred at the ti                     | me, date     | and place, a             | and due to the           | cause(s   | ) and manner a             | s stated.  |
|                            | he H<br>in 24<br>he F<br>plete   | Medical        | one)  | and manner s                     | tated.       | tion and/or in   |  |              |                          | od at the tane,          | uate and  | piace, and du              | e to the cause(s)                                |
|                            | To t<br>To t   | Σ              | 29b. Signature and title certifier  | 1-                               | 1-           |  | 29c. Licens                              |              |                          | 1                        |           | te signed (Mon             |  |
|                            |  |                | May Ind   | H-UM                             |              |  | RES                                      | -0           | 70                       | 4                        | عکدو      | MER                        | 24,2005  |
| . 1                        | 1  |                | 30. Name and address of person who  | completed cause of               | death (Item  | 23а) (Туре,  | Print)                                   |              |                          | 20                       | _         | WI FF A                    | -000T-0  |
| 4                          |  |                | AKIL MERCHANT   |                                  |              |  | us Hosp                                  | ITA          | L 60                     | X) NOR                   | 11+ V     | WUTE ST                    | REET BALTIMY                                     |
|                            | Sta  |                | 31. Date filed (Month, Day, Year)   | 32. Regist                       | rar's Signa  | iture  | 20                                       |              |                          |                          |           |                            | 18021  |
|                            | Regist   | rell.          | DEC 3 0 2005  | Bee bear                         | A.S.         | Jan Barrell  |  |              |                          |                          |           |                            |  |

|                            |   | _              | 1 - For<br>State<br>Registrar   | State of Mar   | ryland / [            | Departm<br><i>Certific</i>       |                                       |                                       | Mental Hy                         | giene<br>Reg. No. | 05 t                             | 2183                                |
|----------------------------|---|----------------|---|--|-----------------------|----------------------------------|---------------------------------------|---------------------------------------|-----------------------------------|-------------------|----------------------------------|-------------------------------------|
|                            |   |                | Decedent's Name (First, Middle, La  | st)  |                       |                                  |                                       |                                       | 2. Date of De                     | aath              | ·                                | 3. Time of Death                    |
|                            | Physici<br>/Medio   |                | Brian Lee Kellih  | er   |                       |                                  |                                       |                                       | Decemb                            | er 20.            | 2005                             | 14:25 M                             |
|                            | Examin  |                | 4a. Facility Name (If not institution, giv                                  | •  |                       |                                  | City, Town, or                        | Location of Dea                       | ith                               | 4c. Col           | unty of Death                    |                                     |
|                            |   |                | Baltimore Washing 5. Social Security Number 6. S                            |  | L Cente               |                                  | Baltin                                | IOre                                  | s. 8. Date of Bir                 |                   | e Arun                           |                                     |
|                            | Funeral Director  |                | -   | M 2□F 32   |                       | Yrs. Mon                         |                                       | Hours Mir                             | . (Month, Da                      | ay, Year)         | 9. Birthp<br>Coun                |                                     |
|                            | ס   |                | Usual Residence of Decedent   |  |                       |                                  |                                       |                                       | верс.                             | 14, 15            | 775 Mar                          | yrand                               |
|                            | anylar<br>show  | _              | 10a. State 10b. County  |  | 10c. City, Tow        |                                  |                                       |                                       |                                   |                   | 1                                | 0d. Inside City Limits              |
|                            | the M   | Director       | Maryland Anne Aru   | ndel   | Glen B                |                                  | 7:- 0-1-                              |                                       |                                   | 10.00             |                                  | 1 ☐ Yes 2 反 No                      |
|                            | with<br>the or  | ក់             | 7432 Furnace Bran   | ch Rd  |                       |                                  | . Zip Code<br>1060                    |                                       |                                   |                   | of What Coun                     | .,                                  |
|                            | daath<br>ms 23  | Funeral        | 11. Marital Status  | 12. Was Decedent Ev  | ver in U.S.           |                                  |                                       | spanic Origin? (                      | Specify Yes or Norto Rican, etc.) |                   | d State                          | an Indian,                          |
| Maryland 21215-0036        | n 72 hours after death with the Maryland<br>"netural", or items 23e or 28e-f ehow<br>salical Exemitrational be notified at  | þ              | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced                      | Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:                   |                       |                                  | specify Cuba<br>es 2⊠No               | n, Mexican, Pue<br>Specify:           | rto Rican, etc.)                  | -                 | Black, White,<br>ecity:<br>White |                                     |
| 5-0                        | 72 h  | etec           | 15. Decedent's Ed<br>(Specify only highest gra                              | Jucation<br>de completed)  | 16a                   | Decedent's t                     | Usual Occupa                          | ation<br>during most of w             | orkina                            | 16b. Kind o       | of Business/Inc                  | dustry                              |
| 121                        |   | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                       |                                  |                                       | furing most of w                      | ······g                           |                   |                                  |                                     |
| Q 7                        | be filed withintal Hygiane. d other then  |                | 17. Father's Name (First, Middle, Last)                                     |  | Ca                    | rpente                           | L                                     | 18 Mother's Na                        | me (First, Middle                 |                   | ruction                          | n                                   |
| au                         | og la bo  | To Be          | Robert L. Kellihe   |  |                       |                                  |                                       |                                       | C. Barne                          |                   | mame)                            |                                     |
| ary                        | S D E E   | -              | 19a. Informant's Name/Relationship (  |  | 19b                   | . Mailing Add                    | ress (Street a                        |                                       | Tural Route Numb                  |                   | wn, State, Zip                   | Code)                               |
|                            | 1 and 2<br>Health a<br>tem 27 is  |                | Carol A. Killiher   | / Wife   | 7                     | 432 Fu                           | rnace                                 | Branch :                              | Rd., Gle                          | n Burn            | ie, MD                           | 21060                               |
| Baltimore,                 | of t  |                | 20a. Method of Disposition 1 ⊠ Byrial 2 ⊖ Scemation 3 □                     | Removal from State   | 20b. Place of cemeter | f Disposition (<br>ry, crematory | (Name of<br>or other place            | e) Dec                                | Date<br>2. 23                     |                   | on - City or To                  |                                     |
| ţ                          | permit. Pag<br>Depertment<br>Important:<br>eny injury o   |                | 4 □ Donation 5 □ Other (Specif  | v)   | Crest                 | lawn Me                          |                                       | r.   20                               | 005                               | Matti             | ottsvil                          | lle, MD                             |
| Bal                        | permit. Pag<br>Depertment<br>Important: I<br>eny Injury o<br>gnca.  |                | 21. Signative of Foreral Serv Licer   |  |                       | Kirk<br>421                      | Crain                                 | ddick Fr<br>Hwy., S                   | uneral Ho<br>.E., Gle             | n Burn:           | A.<br>ie, MD                     | 21061                               |
|                            |   |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only | plications that caused the   | he death. Do i        | not enter the                    | mode of dying                         | g, such as cardia                     | c or respiratory a                | rrest,            |                                  | Approximate<br>Interval Between     |
|                            | Physician   |                | Immediate Cause (Final disease or condition resulting in death)             | a Head in  | Imes                  |                                  |                                       |                                       |                                   |                   |                                  | Onset and Death                     |
|                            | /Medical<br>Examiner  |                | ( Southing an additity  | Due to (or as a  | consequence           | of):                             |                                       | _                                     |                                   |                   |                                  |                                     |
|                            | *   | er             | Sequentially list conditions, if any, leading to immediate                  | b. Due to (or as a   | consequence           | of):                             |                                       |                                       |                                   |                   |                                  | -                                   |
|                            | cuted<br>nd<br>ransit   | Examin         | cause. Enter Underlying Cause (Disease or injury that initiated events      | c  |                       |                                  |                                       |                                       |                                   |                   |                                  |                                     |
| Ö,                         | e exe<br>lan ar<br>urial-t  | Ex             | resulting in death) Last  | Due to (or as a  | consequence           | of):                             |                                       |                                       |                                   |                   |                                  |                                     |
| 68760,                     | ificate be executed<br>g physician and<br>as the burial-transit   | edical         |   | d  |                       |                                  |                                       |                                       |                                   |                   |                                  |                                     |
|                            |   | /Me            | IF FEMALE:  | 23c. If yes, outcome of  | pregnancu             |                                  |                                       |                                       |                                   |                   |                                  |                                     |
| . Box                      | death cert<br>ie ettending<br>ad for use a  | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No            | 1 ☐Live birth 2<br>4 ☐ Pregnant at tir                                     | Fetal death           | 3 □Ectopi<br>5 □ Other           | ic pregnancy<br>(specify)             |                                       |                                   | 23d.              | Date of deliver<br>Month         | ry<br>Day Year                      |
| P.O.                       | at the  | Phys           | 9 ☐ Unknown   | 9⊡Unknown  |                       |                                  |                                       |                                       |                                   |                   |                                  |                                     |
| Division of Vital Records, | The law requires that the death cer<br>sie has been signed by the ettendin<br>page 2 should be detached for use   | þ              | Part II. Other significant conditions of                                    | ontributing to death but   | not resulting in      | the underlying                   | ng cause give                         | in in Part I.                         | 23e. Did t                        | 92-               |                                  | e cause of death?<br>ably 4 Unknown |
| ecc                        | has be  | Completed      |   |  |                       |                                  |                                       |                                       | 24a. Was                          |                   | b. Were autor                    | osy findings available              |
| a<br>H                     |   | Con            |   |  |                       |                                  |                                       |                                       | perfo                             | rmed?<br>2 ☐ No   | death?                           | 2 No                                |
| Vita<br>Vita               | Physicien: T<br>rthis certificet<br>ral director, pa  | Be             | 25. Was case referred to medical examiner?                                  | Hospital:  | - 133                 |                                  | Otho                                  | _                                     | ath (Check only o                 |                   |                                  |                                     |
| ō                          | Phys<br>r this<br>oral di   | 1: To          | 1XXYes 2 □ No<br>27. Manner of Death  | 1 ☐ Inpatient 28a. Date of Injury  |                       | tpatient 3                       | DOA Othe                              | 4 🗆 Nuising i                         | dome 5 Resident                   |                   |                                  | )                                   |
| Ö                          | Attending r death.  | ation          | 1 ☐Natural 5 ☐ Pending 2 ☑ Accident investigation                           | (Month, Day Y  | rear) I               | OSP M                            | 28c. Injury<br>Work                   | ?`<br>'es 2⊠No                        | pedest                            |                   |                                  |                                     |
| Vis                        | ar deg  | Certification; | 3 Suicide 6 Could not be determined   |  | / - At home, fa       |                                  |                                       |                                       | 28f. Location (S                  | Street and Nu     | imber or Rural                   |                                     |
| ā                          | ital or<br>irs efter<br>rat Dire  | Cer            |   |  | Ret                   |                                  |                                       |                                       | Fur nuce                          | n, State)         | ed Cour                          | y Club Drive                        |
|                            | To the Hospital or Attending Physicien: which ad house steller death is certific to the Funeral Director: After this certific completely filled in by the funeral director, | Medical        | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam              | ysician: To the best of a<br>niner: On the basis of ea<br>and manner state | xamination and        | , death occur<br>d/or investigat | red at the tim<br>tion, in my op      | e, date and place<br>inion, death occ | a and due to the                  | course(s) and     |                                  | A                                   |
|                            | To the<br>within 2<br>To the<br>comple  | M              | 29b. Signature and title of certifier                                       | 0  |                       |                                  | 29c. License                          | number                                |                                   | 29d. Date sig     | ned (Month, E                    | Day, Year)                          |
|                            |   |                | Joshrye   | of Mis   |                       |                                  | 0                                     | .C.M.E.                               |                                   | Decemb            | er 21,                           | 2005                                |
|                            | 7   |                | 30. Name and address of person who  |  | th (Item 23a) (       |                                  | · · · · · · · · · · · · · · · · · · · |                                       |                                   |                   |                                  |                                     |
|                            | -0:   |                | Tasha Z Green b. 31. Date filed (Month, Day, Year)                          |  | e Cion stur           | 111 Pe                           | enn Sti                               | ceet, Ba                              | ltimore,                          | Mary1             | and 21                           | 201                                 |
|                            | Sta<br>Registr  |                | DEC 3 0 20  | 32 Registrar's   | s olynature           | South                            | 9                                     |                                       |                                   |                   |                                  |                                     |

|                     | 05-0844<br>Tony D.  |                  | Please<br>Amend it  | Type or Pringle in #23a . I<br>State of M     | t in Black                              | Indelik<br>erME                           | le ink                    | Ensure A                                  | II Copies                           | Are Legible              |                                       |
|---------------------|---|------------------|---|---|---|---|---------------------------|---|-------------------------------------|--------------------------|---------------------------------------|
|                     | 1011y D.  |                  | 1 - State Registrar   | State of Ma                                   |   | epartme<br>Certifica                      |                           |   |                                     | Ca O O W                 | 42184                                 |
|                     |   |                  | Hegistrar     Decedent's Name (First, Middle, La  | st)   |   |   | 110 01                    |   | 2. Date of Deal                     | eg. No.<br>th            | 3. Time of Death                      |
| ı                   | Physici   |                  | Tony  | Douglas                                       |   |   | Mas                       | son                                       | Decembe                             | r ¼, 2ŎC                 | 5 12:55 A M                           |
|                     | /Medio<br>Examin  |                  | 4a. Facility Name (If not institution, giv  |   |   | 4b. C                                     |                           | or Location of Deatl                      |                                     | 4c. County of D          |                                       |
| 1                   | Examir  | er               | 7200 Baltimore Av   |   |   |   |                           |   |                                     | ,                        |                                       |
|                     | Funeral   |                  | 5. Social Security Number 6. S  |   | e (In yrs. last birth                   | day) If Un                                | der 1 Year                |   | 8. Date of Birth                    | Prince 9.                | George's Birthplace (State or Foreign |
| 2                   | Director  |                  | 429-06-7562   |   | 47 Yr                                   | s. Month                                  | ns Days                   | Hours Min.                                | 8. Date of Birth<br>June 22         | , Year 1958 Ar           | Kansas                                |
| 7                   | p .   |                  | Usual Residence of Decedent   |   |   |   |                           |   |                                     |                          |                                       |
|                     | how   | _                | 10a. State 10b. County  | _   | 10c. City, Town                         |   |                           |   |                                     |                          | 10d. Inside City Limits               |
|                     | Sa-f.   | 5                | Arkansas Garlan   | d   | Pear                                    | су  |                           |   |                                     |                          | 1 ☐ Yes 2 X No                        |
|                     | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Itams 23s or 28s-f show<br>he Madical Examiner must be notified at  | Funeral Director | 10e. Street and Number  |   |   |   | Zip Code                  |   | 1                                   | 0g. Citizen of What      | Country?                              |
|                     | 238 238   | rail             | 159 Parkway Squa  | re  |   |   | 71964                     |   |                                     | USA                      |                                       |
|                     | and and and and and and and and and and   | au.              | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?             | Ever in U.S.                            | 13. Was De<br>If Yes, s                   | cedent of F<br>pecify Cub | lispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No-<br>o Rican, etc.) | 14. Race - A<br>Black, W | merican Indian,<br>hite, etc.         |
| 36                  | or it   | Y.               | 1 Never Married 2 Married   | 1 ☐ Yes 24 ☐                                  | No                                      |   | 2 No                      |   |                                     | Caraif                   | hite                                  |
| 8                   | ural'   | Q D              | 3 Widowed 4 Divorced  | Year or Dates:                                | 1.10. 8                                 |   |                           |   |                                     |                          |                                       |
| 5                   | n 72<br>nat   | lete             | 15. Decedent's E<br>(Specify only highest gra   | de completed)                                 | (4                                      | ecedent's U<br>Give kind of<br>ife. DO NO | work done                 | during most of wor                        | rking                               | 16b. Kind of Busine      | ss/Industry                           |
| 12                  | withii<br>ene.<br>then  | Completed by     | Elementary/Secondary (0-12)   | College (1-4or t                              | 5+) [                                   | rse                                       | 430 101/10                | 0)  |                                     | Health Ca                | re                                    |
| 92                  | filed withi<br>Hygiene.<br>other then   |                  | 17. Father's Name (First, Middle, Last,   | <u> </u>                                      |   |   |                           | 18. Mother's Nan                          | ne (First, Middle, I                | Maiden Sumame)           | -                                     |
| an                  | ould be<br>Mental<br>Arked o  | To Be            | Doug Mason  |   |   |   |                           | Nellie                                    | Jean Ca                             | rter                     |                                       |
| Maryland 21215-0036 | 2 should and Men ls marke   | F                | 19a. Informant's Name/Relationship (  | Type, Print)                                  | 19b. N                                  | Mailing Addr                              | ess (Street               | and Number or Ru                          | ral Route Number                    | City or Town, State      | e. Zip Code)                          |
| Σ                   | od 2 :  |                  | Shelli Mason  | (Wife)  |   |   |                           |   | earcy, A                            |                          | 71964                                 |
| ē,                  | ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If Itam 27 is marked other than "natural", or Itams 23s or 28s-f show or other traumatic avant, the Madical Examinar must be notified at |                  | 20a. Method of Disposition  |   | 20b. Place of C                         |   | Varne of                  | -   |                                     | 20c. Location - City     | or Town, State                        |
| 9                   | age<br>ent o<br>nt: if  |                  | 1 XBurial 2 Cremation 3 C<br>4 Donation 5 Other (Specif   |   | Morning                                 |   |                           |   | -20-05                              | Hot Sprin                | gs, Arkansas                          |
| Baltimore,          | permit. Pages 'Department of h<br>Important: If its<br>eny injury or of   |                  | 21. Signature of Funeral Service Lice   |   |   |   |                           | es of Facility<br>Ith Funer               |                                     |                          |                                       |
| ä                   | Depa<br>Impo<br>eny ir  |                  | Malen 1:11  | Ando  | 00                                      |   |                           |   |                                     | ings, AR                 | 71913                                 |
|                     |   |                  | 23a. Part1 Enter the disease, or com  | plications that caused                        | the death. Do no                        |   |                           |   |                                     |                          | Approximate                           |
|                     |   |                  | Immediate Cause (Final  | one cause on each II                          | <sup>ne.</sup> Hyperten                 | sive at                                   | herosc                    | lerotic car                               | rdiovascula                         | r disease                | Interval Between<br>Onset and Death   |
| 7                   | Priysician<br>/Medical  |                  | disease or condition resulting in death)  |   | ad by Zolpic<br>a consequence of        |   | Dien)                     | and ethano.                               | . use                               |                          |                                       |
| ı                   | Examiner  |                  |   |   | u 0011004201100 017                     | •   |                           |   |                                     |                          |                                       |
|                     |   | ē                | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Due to (or as                                 | a consequence of)                       | :   |                           |   |                                     |                          |                                       |
|                     | uted  | Examine          | Cause (Disease or injury that initiated events  | <b>C</b> .                                    |   |   |                           |   |                                     |                          |                                       |
| oʻ                  | e executed<br>tien and<br>urial-transit   | Exa              | resulting in death) Last  |   | a consequence of)                       | :   |                           |   | <del></del>                         |                          |                                       |
| 19/                 | icate be<br>physicie<br>s the bur   | cai              |   | d   |   |   |                           |   |                                     |                          | 1                                     |
| 9289                | ufficat<br>g phy<br>as th   | ed               |   |   |   |   |                           |   |                                     |                          |                                       |
| Box                 | death certificate be executed<br>e attending physicien and<br>of for use as the burial-transit  | Ş                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. tf yes, outcome                          | of pregnancy<br>2   Fetat death         | 2.00                                      |                           |   |                                     | 23d. Date of             | delivery                              |
|                     | death   | icia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4 ☐ Pregnant at                               |   | 3 □Ectopic<br>5 □ Other                   |                           | ·   |                                     | Month                    | Day Year                              |
| P.0                 | The law requires that the de<br>tte hes been signed by the a<br>vage 2 should be detached i   | Physician/Medica | 9 ☐ Unknown   | 9□ Unknown                                    |   |   |                           |   |                                     |                          |                                       |
|                     | es tha<br>igned<br>be de  | by F             | Part II. Other significant conditions of  | ontributing to death b                        | out not resulting in t                  | ne underlyin                              | g cause giv               | ren in Part I.                            | 23e. Did tot                        | acco use contribute      | to the cause of death?                |
| pro                 | v require<br>been si  |                  | Liver cirrhosis   |   |   |   |                           |   | 1 □ Ye                              | s 2 □ No 3 □             | Probably 4 Unknown                    |
| Records,            | aw rec<br>s bee<br>2 shou   | Completed        |   |   |   |   |                           |   | 24a. Was a                          |                          | autopsy findings available            |
| Œ                   | The lav   | Eo               |   |   |   |   |                           |   | autops<br>perform<br>1 X Yes 2      | ned?   death             |                                       |
| Vital               |   | Be C             | 25. Was case reterred to medical  |   |   |   |                           | 26. Place of Dea                          | th (Check only on                   |                          | 63 2 110                              |
| <b>†</b>            | ysic<br>direct  | To E             | examiner?<br>1.□Yes 2□ No   | Hospitat:                                     | ent 2 ER/Outp                           | atient 3                                  | DOA Dth                   | ner: 4 🗆 Nursing H                        | lome 5 Reside                       | ence 6 🔲 Other (S        | pocity) AT SCENE                      |
| J of                |   |                  | 27. Manner of Death 1 ■ Natural 5 □ Pending   | 28a. Date of Inju                             | y Year) 28b. Tin                        |   | 28c. Injur<br>Wor         | y at                                      | 28d. Describe ho                    | w injury occurred        |                                       |
| 0                   | Attending<br>ir death.<br>ector: After<br>by the fune   | atic             | 2 ☐ Accident investigation  | 1   | , | м   |                           | Yes 2 □ No                                |                                     |                          |                                       |
| Division            | or Attene<br>effer deatl<br>Director:<br>in by the  | Certification:   | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  | 28e. Place of Inj                             | ury - At home, tarm<br>c. (Specify)     | , street, fac                             | ory, office               |   | 28t. Location (St.<br>City or Town  | reet and Number or       | Rural Route Number,                   |
|                     | dospital or A<br>t hours efter<br>uneral Dire   | Cer              |   | 355   | ,=r//                                   |   |                           |   | ,                                   |                          |                                       |
|                     | Hospital<br>24 hours e<br>Funeral I<br>tely filled  | edical           | 29a. Certifier 1 Certifying Pt  | ysician: To the best<br>niner: On the basis o | of my knowledge. of examination and/    | death occurr                              | ed at the tir             | me, date and place                        | and due to the ca                   | ause(s) and manner       | as stated                             |
|                     | o the Hos<br>ithin 24 h<br>o the Fun<br>ompletely   | Medi             | one)  | and manner st                                 | ated.                                   |   |                           |   |                                     |                          |                                       |
|                     | 0 = 0 5   | 4                | 29b. Signature and title of certifier   |   |   |   | 29c. Licens               | e number                                  | 1 29                                | 9d. Date signed (Mo      | חוח. Dav. Year)                       |

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2131 UCOH 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Morth, (Day, Year) 2005

2. Registrar's Signature

29c. License number

OCME

29d. Date signed (Month, Day, Year)

December 15, 2005

|  |                     | State of Maryland / Department of Health and Mental Hygiene 05 42185   |
|--|---------------------|--|
|  |                     | 1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death   |
| Physic<br>/Med   |                     | Ruth Adell Maxwell December 25, 2005 4:000 M   |
| Exami  |                     | 4a. Facility Name (If not institution give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c. Sounty  Director   |                     | 218-64-0800 1 M 2X F 78 Yrs. Months Days Hours Min. (Month, Day, Year) 9-25-1927 S.C.  |
| yland  |                     | 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits   |
| h the Marylan<br>r 28a-f ehow  | ctor                | Md N/A Balto 1∑Yes 2□No  |
| with th  | Dire                | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?   |
| death with   | era                 | 2095 Rockrose Avenue 21211 U S A  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,  |
| ō = □  | by Funeral Director | 11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 □ Yes 2 ☑ No  1 □ Yes   |
| 215-0036 ithin 72 hours atl  | eted                | 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry, TX 1   |
| 21212<br>1 within<br>1 within<br>1 within<br>1 men "   | Completed           | Elementary/Secondary (0-12) College (1-4or 5+)   |
| C TIST   | ပိ                  | 10th grade N/A Housekeeping  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)   |
| ylan<br>ylan<br>ould be<br>Mental<br>merked o  | To Be               | Duncan Solmon Jennie Atkins  |
| S sh and and and and and and and and and and   |                     | 19a. Informant's Name/Relationship (Type, Print)  Walter Maxwell- Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  3707 Overview Road Balto, Md 21215   |
| or Health  |                     | 20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State  |
| altimore, mil. Pages 1 a partment of He portant: If Item portant: If Item portant of the partment of the portant of the portant if Item portant of the page. |                     | 4 Donation 5 Other (Specify) King Memorial Park 12-31-2005 Randallstown, Md  |
| Baltim<br>permit. Par<br>Departmen<br>Important:<br>eny Injury   |                     | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Balto, Md 21215   |
|  |                     | 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.  Immediate Cause (Final  |
| Physician<br>/Medical  |                     | Immédiate Cause (Final diséase or condition resulting in death)  Onset and Death  Onset and Death  |
| Examiner   | Ш                   | Congective Hourt to: lure  |
| lasit ted  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):   |
| 760, to be executed ysicien end to burial-transit  |                     | that initiated events c.  resulting in death) Last Due to (or as a consequence of):  |
| 2 2 20   | dical               |  |
| , P.O. Box 68<br>that the death certifical<br>ted by the ettending phy<br>detached for use as th   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   |
|  | by Pt               | Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?   |
| ord<br>require   |                     | 1 Yes 2 No 3 Probably 4 Unknown  |
| I Re   | Completed           | 24a. Was an autopsy findings available prior to completion of cause of death?  1   |
| of Vital B<br>Physician: Th<br>this certificate  | Be                  | 25. Was case referred to medical examiner?  Hospital: Check only one  Check  |
| Of 1<br>Phys   | . To                | 27. Manner of Death  28a. Date of Injury  28b. Time of  28c. Injury at  28d. Describe how injury occurred  |
| nding<br>ath.<br>or: Afte  | atlor               | 2 Accident investigation M 1 Yes 2 No  |
| Divis<br>al or Atto<br>s effer de<br>al Directo  | Certification;      | 3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| Division of To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral di        | edical              | 29a. Certifier  (Check only one)  1. Certifier  (Check only one)  1. Certifier  (Check only one)  1. Certifier  (Check only one)  1. Certifier  (Check only one)  1. Certifier  (Check only one)  2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |
| To th<br>withir<br>To th   | Me                  | 29b. Signature and title of certifier  29c. License number 005 / 0 29d. Date signed (Month, Day, Year)   |
|  |                     | 1 1/1000 Vecamber 252005   |
| 3  |                     | 30. Name and Add essyot person who completed cause of death (Item 23a) (Type, Print)   |
| \$490°00'1   | ate                 | 31. Date filed (Month, Day, Year)  32. Pegistrar's Signature  DEC 3 0 2005   |
| Regist   | rar                 | DEC 3 0 2005 Seems St. Aparle  |

|  |                | 1        | State of !   | FH G851                                   | Cen                                      | ficate of L  | Death  |                               |                           | 000                            | Ų,                  | 2100                            |
|--|----------------|----------|--|---|--|--|--|-------------------------------|---------------------------|--------------------------------|---------------------|---------------------------------|
| Physi  | cian           | -        | 1. Decedent's Name (First, Middle, Last)   |   |  |  |  | 2. Date of E                  | Death Da                  |                                | Year                | 3. Time of Death                |
| /Me<br>Exan  |                | -        | ta. Facility Name (If not institution, give street and number  | ər)                                       |  | 4b. City. Town, or                                 | Location of Death                                    | 12                            | 40                        | . County o                     |                     | 10.55 A                         |
| LXaii  | III IÇI        |          | BON SECOURZE HOSP  | Mel                                       |  | ·  | timore   |                               |                           |                                |                     |                                 |
| Funer:<br>Directo  |                | 1        | 226-54-6815 10M 200  | Age (In yrs. last b                       | Yrs.                                     | If Under 1 Year<br>Months Days                     | If Under 24 Hrs.<br>Hours Min.                       |                               | lirth<br>Day, Year,<br>04 | 41                             | 9. Birthpl<br>Count | lace (State or Foreign<br>try)  |
| land w   |                | $\vdash$ | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, To                             | wn or Loc                                | ation  |  |                               |                           | ··                             | 10                  | 0d. Inside City Limits          |
| Many<br>-fehc  | Į              | 5        | MD NA  | Ва  | alti                                     | more   |  |                               |                           |                                |                     | 1 Yes 2 No                      |
| ith the Marylar<br>or 28a-f ehow   | Director       | 3        | 10e. Street and Number   |   |  | 10f. Zip Code                                      |  |                               | 10g. Ci                   | tizen of Wi                    | nat Coun            | try?                            |
| ath wi   |                |          | 1801 North Rosedale S  | treet                                     |  | 212  | 16   |                               |                           | U.S.                           | Α.                  |                                 |
| s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It Health and Mental Hygiene with the marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examination into the profitted at   | by Funeral     | ) - A    | 11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decede Armed Force 1 Yes Give Year or Date | s?<br>X No                                | 1  | as Decedent of Hi<br>Yes, specify Cuba<br>Yes 2 No | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No Rican, etc.) | io-                       | 14. Race<br>Black,<br>Specify: | White, e            | etc.                            |
| ed within 72 hours afgiene.  ar than "natural", or the Medical Exem.   | Pe             | -        | 15. Decedent's Education   |   | ia. Decede                               | ent's Usual Occupa                                 | ation  |                               | 16b. K                    | (ind of Bus                    |                     | ack                             |
| hin 72<br>9.<br>Medi   | Completed      | 2        | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4c   |   | (Give k                                  |  | uring most of work                                   | king                          | 100.11                    | WIG 01 DU3                     | 1103341110          | iostry                          |
| ad wit   | Com            | 5        | 12th grade na  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   | N  | ırse   |  |                               | Pr                        | ivat                           | e D                 | uty                             |
| d 2 should be filed within the and Mental Hygiene. 77 ie marked othar than traumatic event, the Mental traumatic e | a              | ם כ      | 17. Father's Name (First, Middle, Last)  |   |  |  | 18. Mother's Nam                                     | e (First, Midd                | e, Maider                 | n Sumame,                      | )                   |                                 |
| should<br>nd Men<br>marka  | Ţ              | 2        | Willie Wilson Sr.  19a. Informant's Name/Relationship (Type, Print)  | 10  | No. Admillion                            | Add (0)  | Carrie   | Lee                           | Hilt                      | on                             |                     |                                 |
| d 2 s<br>Ith an<br>27 ie r<br>traur  | 1              |          |  | 19  | D. Mailing                               | Address (Street a                                  | ind Number or Hur                                    |                               |                           |                                |                     | <sup>Code]</sup> 21216          |
| s 1 and 2 Health itam 27 other tra   |                | -        | Veronica McCall Ward- 20a. Method of Disposition   | 120b, Place                               | of Dispos                                | tion (Name of                                      |  | dale :                        | 20c. L                    | ocation - C                    | ity or lov          | to, Md<br>wn, State             |
| Pages<br>nent of<br>int: If its  |                |          | 1 🔀 Burial 2 □ Cremation 3 □ Removal from Sta  `4 □ Donation 5 □ Other (Specify)   | <sup>te</sup> Mt <sup>cem</sup> C<br>King | arue<br>Mei                              | ory or other place                                 | "<br><del>Par</del> k l∕                             | 6/06                          | Bal                       | timor<br>dall                  | e, M                | Mn, Md                          |
| 그 돈 돈 글  | Buce           | 1        | 21. Signature Funeral Service Licensee   | ,   | 22.                                      | Name and Addres                                    | s of Facility  | 0,00                          | 2.000                     |                                |                     | willy IIG                       |
| 8858   | a              |          | Fremand C. Sky   | nut                                       | 4:                                       | arch F/1<br>300 Wab                                | ash Ave  | , Balı                        | timo                      | re,                            | Md :                | 21215                           |
|  |                |          | 23a Part. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each            | i line.                                   | o not ente                               | the mode of dying                                  | g, such as cardiac                                   | or respiratory                | arrest,                   |                                |                     | Approximate<br>Interval Between |
| Prysicia   | _              | 1        | Immfediate Cause (Final dis e for condition resulting in death)  | FRG                                       | AST                                      | TROINT   | HEM  | NAL                           |                           |                                |                     | Onset and Death                 |
| /Medica<br>Examine   | _              |          | Due to (or   | as a consequence                          | e of):                                   |  | HEM  | ORR                           | HA.                       | GE                             |                     |                                 |
|  | e E            | 5        | Sequentially list conditions, b. Due to (or  | as a consequence                          | e of).                                   |  |  |                               |                           |                                | -                   |                                 |
| be executed<br>sician and<br>burial-fransit  | Examiner       |          | if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                      |   |  |  |  |                               |                           |                                |                     |                                 |
| cate be exect<br>ohysician an  | EX             |          |  | as a consequence                          | e of):                                   |  |  |                               |                           |                                |                     |                                 |
| cate by  | dicai          | 3        | d  |   |  |  |  |                               |                           |                                | -                   |                                 |
| The law requires that the death certificate be executed to has, been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | Physician/Me   |          | IF FEMALE: 23c. If yes, outcor   | ne of oregnancy                           |  |  |  |                               | T                         |                                |                     |                                 |
| atter<br>after<br>I for u  | cian           |          | in the past 12 months?   | 2 Fetal deat                              |  | ectopic pregnancy<br>Other (specify)               |  |                               | 10                        | 23d. Date<br>Month             |                     | Y<br>Day Year                   |
| that the ded by the detached   | hvs            |          | 1 Yes 2 No 9 Unknown   |   |  | (4,)/  |  |                               | -                         |                                |                     |                                 |
| The law requires that is has been signed I age 2 should be det   | bv P           | . 1      | Part II. Other significant conditions contributing to death  | but not resulting                         | in the und                               | lerlying cause give                                | n in Part I.   | 23e. Did                      | tobacco                   | use contrib                    | ute to the          | e cause of death?               |
| w require<br>been signated   | ted            | 3        |  |   |  |  |  | 1 🗆                           | Yes 2                     | ☑No 3                          | ☐ Proba             | ably 4 Unknown                  |
| e law re<br>has be   | Completed      | -        |  |   |  |  |  | 24a. Wa                       | s an<br>opsy              | 24b. We                        | ere autop           | sy findings available           |
|  | Con            |          |  |   |  |  |  | per<br>1 Yes                  | formed?<br>2 No           | → de                           | ath?                | 2□ No                           |
| Physician: The this certificate ral director, pag  | 9              |          | 25. Was case referred to medical examiner?  Hospital: Hospital:  |   |  | 0#-  | 26. Place of Deat                                    | h (Check only                 | one)                      | -                              |                     |                                 |
| Phys<br>r this<br>ral die  | 100            | 11       | 1 ☐ Yes 2 ☑ No ☐ Nospital 1 ☐ Inpa<br>27. Mann Death 28a. Date of It   |   | Outpatient . Time of                     | 3 □ DOA Othe                                       | 4   Nursing Ho                                       | ome 5 Res                     |                           |                                |                     | )                               |
| or Attending Fafter death.  Diractor: After In by the funeri   | tion           |          |  |   | Injury                                   | Work   | es 2 □ No  | 280. Describe                 | now injui                 | ry occurred                    | 1                   |                                 |
| To the Hospital or Attending within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune  | Certification: |          | 3 Suicide 6 Could not be 28e. Place of   | Injury - At home, f<br>etc. (Specify)     | farm, stree                              |  |  | 28f. Location                 | (Street an                | nd Number                      | or Rural            | Route Number,                   |
| ital or A<br>rs after<br>ral Dirac   | Cer            | 3        | /  | oto. (Opoony)                             |  |  |  | Only or re                    | own, State                | 9/                             |                     |                                 |
| To the Hospital or within 24 hours afte To the Funaral Dir. completely filled in the completely filled in the second of the formation of the f | ical           | 1        | 29a. Certifier 1 Certifying Physician: To the be continuous continuous 2 Medical Examiner: On the basis                  | of examination a                          | ge, death o                              | occurred at the timestigation, in my op            | e, date and place,<br>inion, death occur             | and due to the                | e cause(s)                | ) and mann                     | ner as sta          | ited.                           |
| thin 2<br>the<br>mplel   | Medical        | -        | one) and manner  | stated.                                   |  | 29c. License                                       |  |                               |                           | te signed (                    |                     |                                 |
| 5. <u>₹</u> 5.8  |                |          | DEdward Sycanom  | D   |  | 021  | 997  |                               | 290. Da                   | te signed (                    | monun, L            |                                 |
| 7  |                | -        | 30. Name and address of person who completed cause of  | f death (Item 224)                        | ) (Type P                                | rint)  | 117  |                               | <u> </u>                  | <u> </u>                       | C 1                 | 2007                            |
| 0  |                |          | EDWARD BOLFLANO  | MJ (Nem 23a)                              | 20                                       | 200 h  | BAL  | Tim                           | ORS                       | = =                            | 57                  |                                 |
|  | itatė          |          | 31. Date filed (Month, Day, Year) 32. Regi   | strar's Signature                         | · · · · · ·                              |  |  | - 7                           |                           |                                |                     |                                 |
| Regi   | strar          | è        | DEC 3 0 2005   | 11  | dos                                      | 18.3   |  |                               |                           |                                |                     |                                 |
| HMH 17 Rev   | 1/2001         |          |  | many of the                               | S. S. S. S. S. S. S. S. S. S. S. S. S. S |  | MARIE - CO   |                               |                           |                                |                     |                                 |
|  |                |          | -1,0   | OR  | IGINA                                    | ion .  |  |                               |                           |                                |                     |                                 |

UNK

|                |   | •                | 1 - For<br>State<br>Registrar   | State of Marylar  |  | nent of Health and cate of Death                                    | Mental Hygien   | 000                                 | 12187  |
|----------------|---|------------------|---|---|--|---|---|-------------------------------------|--|
|                | Physicia  | an               | Decedent's Name (First, Middle, Last  |   | DREAL  | 1   |   | ay Year                             | 3. Time of Death                                   |
|                | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give   |   |  | City, Town, or Location of Dea                                      |   | 22, 2005<br>c. County of Death      | 10:55 P M  |
|                | LXdiiiii  | C1               | I-95 North  |   | В  | altimore City   |   | N/A                                 |  |
|                | Funeral<br>Director   |                  | 5. Social Security Number  317-/3-7770  Usual Residence of Decedent   | 7. Age (In yrs. 26  |  | Inder 1 Year If Under 24 Hrs<br>onths Days Hours Min                |   | 9. Birth<br>Cou                     | place (State or Foreign intry)  MD .               |
|                | yland   | Ì                | 10a. State 10b. County  | 10c. Ci   | ty, Town or Location                         | 1   |   |                                     | 10d. Inside City Limits                            |
|                | e Mar   | ctor             | MD. NA  | $\mathcal{B}_{i}$   | HITIMO                                       | KE  |   |                                     | 1 Tes 2 No   |
|                | with the or 2   | Funeral Director | 10e. Street and Number  | MAC ST.   | 10   | f. Zip Code 2/224   | 10g. C  | Citizen of What Cou                 | untry?   |
|                | death<br>me 23  | nera             | 11. Marital Status  | 12. Was Decedent Ever in U  | S. 13. Was I                                 | Decedent of Hispanic Origin? (S<br>specify Cubas, Mexican, Puer     | Specify Yes or No-                                    | 14. Race - Amer                     |  |
| 21215-0036     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itame 23s or 28s-f show appringuty or other traumatic avant. The Medical Examinar must be notified at ance. | þ                | 1 ☑ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced   | Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:                              |  | es 2 No Specify:  | no Hican, etc.)                                       | Specify:                            | HITE   |
| <u>5</u>       | "natu   | Completed        | 15. Decedent's Edi<br>(Specify only highest grad  | ication<br>le completed)  | 16a. Decedent's<br>(Give kind                | Usual Occupation of work done during most of wo OT use retired)     | orking 16b.   | Kind of Business/li                 | ndustry  |
| 72             | d within  | ошо              | Elementary/Secondary (0-12)   | College (1-4or 5+)  | MEC  | 14.   | 17  | TRUCK                               | 5  |
|                | al Hyg  | Be C             | 17. Father's Name (First, Middle, Last)   |   | -  | 18. Mother's Na   | me (First, Middle, Maide                              | n Surname)                          |  |
| Maryland       | J Ment<br>Marked<br>Marked  | ၉                | WILLIAM   | YORGAN JA   |  | LIN   | DIA BITTI   | NGER                                |  |
| <u>a</u>       | th and 2 st lith and 27 is n  |                  | 19a. Informant's Name/Relationship (T   | 6i4iU   | 90 T. C.                                     | dress (Street and Number or R                                       | T. BAJ  | MORE                                | ip Code) シンプルタ                                     |
| Jre,           | of Hearlitam  |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3  |   | Place of Disposition cometery, cremator      |   | Date 20c.   | Location - City or T                | own, State   |
| Ē              | Page<br>Iment<br>tant: if   |                  | 4 ☐ Donation 5 ☐ Other (Specify,  | ) 0   | AVVIEU                                       | OREM. DE  | 2005 B  | HIO,                                | MD.  |
| Baltimore,     | permit<br>Depart<br>import<br>any in  |                  | 21. Signature of Funeral Service Licens   | Kordo Ji  | SK   | ne and Address of Facility  | 2829 HL   | 14D-21                              | 224  |
| H              |   |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of                             | lications that caused the deal<br>one cause on each line.                           | th. Do not enter the                         | mode of dying, such as cardia                                       | ic or respiratory arrest,                             |                                     | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician /Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | a. Due to (or as a consec   | itiple inju                                  | nes   |   |                                     |  |
|                | Examiner  |                  | Constitution and divine   | b   | quence or,                                   |   |   |                                     |  |
| 1              | sit ad  | iner             | Sequentially list conditions, if any, leading to anneutate cause. Enter Underlying Cause (Disease or injury | Due to (or as a sonesc  | quenes of):                                  |   |   |                                     |  |
| V              | xecute<br>and<br>al-tran  | Examiner         | that initiated events<br>resulting in death) Last   | c   | quence of):                                  |   |   |                                     |  |
| 68760,         | ficate be executed<br>physicien and<br>s the burial-transit   | edicai E         | l   | d   |  |   |   |                                     |  |
| _              |   | Medi             | IF FEMALE:  |   |  |   |   | T.                                  |  |
| Вох            | that the death certifi<br>ed by the attending<br>detached for use as  | Physician/M      | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta                            | al death 3 □Ecto                             | pic pregnancy   |   | 23d. Date of deliv<br>Month         | very<br>Day Year                                   |
| о.<br>О.       | the de<br>y the a   | ysic             | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of c<br>9□ Unknown   | Jeath 5 Oth                                  | er (specify)  |   | 2                                   |  |
|                | res that<br>signed b  | by PI            | Part II. Other significant conditions co  | ntributing to death but not res   | sulting in the underly                       | ring cause given in Part I.   | 23e. Did tobacco                                      | use contribute to                   | the cause of death?                                |
| ord            | w require<br>been si<br>should I  | ted              |   |   |  |   | 1 🗆 Yes   | 2 No 3 □ Pro                        | bably 4 Dunknown                                   |
| Vital Records, | 4 S CA  | Completed        |   |   |  |   | 24a. Was an autopsy performed?                        | death?                              | opsy findings available ompletion of cause of      |
| ita            | sian: '<br>artifica<br>ctor, p  | BeC              | 25. Was case referred to medical examiner?  |   |  | 26. Place of De   | 1  Yes 2  Neath (Check only one)                      | o in ites                           | 2 140  |
| of <           | Physic<br>this co   | ပ္               | 1X Yes 2 No<br>27. Manner of Death  | Hospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury                                     | ER/Outpatient 3[                             |   | Home 5 Residence                                      | 6 € Other (Speci                    | Scene  |
| o              | ding<br>th.<br>: After<br>s funer   | tlon             | 1 Natural 5 Pending 2 Xaccident investigation   | (Month, Day Year)   | 10:43 PM                                     | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 No                             | 28d. Describe how in                                  | wy occurred an                      | ver in   |
| Division       | er dea<br>ractor<br>by the  | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined   |   | iome, larm, street, fa                       |   | 28f Location (Street                                  | and Number or Bur                   | al Route Number                                    |
| ۵              | urs aft<br>srai Di  |                  |   |   | interstate                                   |   | POTO DOUTIME  | e, mi                               | th of mile mark                                    |
|                | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | edical           | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam   | /sician: To the best of my knotiner: On the basis of examination and manner stated. | owledge, death occi<br>ation and/or investig | irred at the time, date and plac<br>ation, in my opinion, death occ | e, and due to the cause(<br>urred at the time, date a | s) and manner as and place, and due | stated.<br>to the cause(s)                         |
|                | To the<br>within<br>To the  | Me               | 29b. Signature and title of certifier   |   |  | 29c. License number   | 29d. D  | ate signed (Month,                  | Day, Year)   |
| )              |   |                  |   | all, mi   |  | OCME .  | Dec   | cember 23                           | , 2005   |
|                | 10  |                  | 30. Name and address of person who co<br>Rivele & Southall, MI) 111   |   |  |   | 202   |                                     |  |
|                | Sta   | te               | 31. Date filed (Month, Day, Year)   | 32. Signatur's Signatur's Signatur  | aturo A                                      |   |   |                                     |  |
|                | Registr   | ar               | DEC 3 0 20  | 105   | K Kan  | <b>强力</b>   |   |                                     |  |

Mullinix, Maurine

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** Ам 4:40 Maurine Roselyn Mullinix December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Oakcrest Care Center Parkville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 29, 191 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Yrs 215-54-3500 Meyersdale. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "neturel", or Items 23a or 28a-f show other treumetic event, the Modical Examinar must be indiffed at Parkville 1 TYes 2 No Mary land Baltimore Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. 21234 United States Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 □ Divorced White 2 should be filed within 72 hours and Mental Hygiene. is markad other then "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years 4 Years Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip N. Reich Christiana L. Beachy ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other treu 2913 Willoughby Road Baltimore, Maryland 21234 Philip Mullinix - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Park 12/29/2005 Baltimore, Maryland <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signay of Fyn Service Licensee Charles F. Miner 22. Name and Address of Facility 5305 Harford Road Baltimore, Maryland Leonard J. Ruck, Inc. 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** angune disease or condition resulting in death) /Medical Due to (dr as a corte equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or a a consequence of): Examine be executed burial-transit resulting in death) Last Due to (or as a consequence of): iding physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2□ No 1 🗆 Yes 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Hospitel or Attending Pl 24 hours after death. Funerel Director: After th Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. Nicense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Mones BLUMENTHA 8800 Mul

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

0 2005 32. Registrar's Signature

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Kathleen 8:49 P Beatley Martin December 23, 2005 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 1823 Mountain Road Joppa If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Days Hours 1 □ M 2 🛛 F Yrs 217-18-2831 83 10, 1922 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 TYes 2 No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1823 Mountain Road 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify 35 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Beatley Charles Lawrence (nmn) Margaret Gross ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles C. Martin / Son 716 Otter Court, Jacksonville, FL 32259 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mountain Christian Cem. 12-28-05 Joppa, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 cussa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ead Immediate Cause (Final disease or condition resulting in death) dea Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant

Physician /Medical Examiner

burial-transit

as the

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page 2 should

director,

the be detached

signed by

certificate has

this funeral

After

after death.

within 24 hours a To the Funeral C

physician

certificate be executed

Box 68760

P.O.

Division of Vital Records,

Hospital or Attending Physician:

To the

Examiner

⋧

Completed

Be

P

Certification:

**Physician** 

/Medical

**Examiner** 

Director

Funeral

δ

Be

**Funeral** 

Director

rthan "natural", or iteme 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

hours after

filed within 72

permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than any injury or other traumetin.

Baltimore, Maryland 21215-0036

If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 1 ☐ Yes 2 110

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

26. Place of Death (Check only one) Other: 1 Inpatient 3□ DOA 4 Nursing Home 5 Indence 6 □Other (Specify, Date of Injury (Month, Day Year) 28b Injury

28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number. City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

son who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2005

Hospital:

29c. License number

29d. Date signed (Month, Day, Year)

D0015673

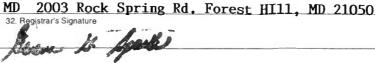
**12-28-20**05

State

31. Date filed (Month, Day, Year)

dress of be

Jospeh A. Reinhardt,



**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical

2 110

5 Pending

investigation

6 Could not be

examiner'

1 Yes

1 Natural

2 Accident 3 Suicide

4 - Homicide

(Check only one)

29a. Certifier

30. Name and a

9 Unknown

ORIGINAL

MEDONAL

|            |  |                | State of Maryland / Department of Health   |  | -                            | •                        |   |
|------------|--|----------------|--|--|------------------------------|--------------------------|---|
|            |  |                | 1- State Registrar Certificate of Death  |  | RegZN                        | 000                      | 42192   |
|            | Physicia   | an             | 1. Decedent's Name (First, Middle, Last)   | Mor  |                              | ay Year                  | 3. Time of Death                                    |
|            | /Medic   | al             | MARY CATHERINE MEYERS  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location   | n of Death                                   |                              | ic. County of Dea        |   |
|            | Examin   | er             | HOWARD COUNTY CENERAL HOSPITAL COLUMB  |  |                              | House                    |   |
|            | Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under   | er 24 Hrs.   8 Date                          | e of Birth<br>onth, Day, Yea | 9. Bi                    | rthplace (State or Foreign                          |
|            | Director   |                | Usual Residence of Decedent  | Jan  | . 20, 1                      | .921 Ma                  | ryland  |
|            | yland<br>how   |                | 10a. State 10b. County 10c. City, Town or Location   |  |                              |                          | 10d. Inside City Limits                             |
|            | Be-fs  | Director       | MD Baltimore Arbutus   |  |                              |                          | 1 ☐ Yes 2 No  |
|            | with the   | Dire           | 10e. Street and Number 10f. Zip Code 1258 Linden Avenue 21227  |  |                              | Citizen of What C        | country?  |
|            | death<br>ms 23   | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O  | Origin? (Specify Ye                          | s or No-                     | 14. Race - Am            |   |
| 9          | or ita   |                | Armed Forces? If Yes, specify Cuban, Mexical 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No type, Give 1 □ Yes 2 □ No Specific   |  | etc.)                        | Black, Wh                |   |
| 21215-0036 | filed within 72 hours after death with the Maryland<br>Hygiene<br>ther than "netural", or flame 23e or 28e-f show<br>ther than "netural", or flame 23e or 28e-f show<br>ant, the Medical Eran are much be troubled at  | Completed by   | 3 ☑ Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation   |  | 16h                          | Kind of Business         |   |
| 215        | hin 72<br>a.<br>an "ne<br>Nedic  | plet           | (Specify only highest grade completed)  (Give kind of work done during mo life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)   | ost of working                               | 100.                         | 1410 01 0001100          | amoustry  |
|            | ed with<br>ygiene.<br>ser than<br>t, than  | Com            | 9 Home Maker   |  |                              | Home                     |   |
| Maryland   | d be fill<br>ntal H<br>ed oth  | Be             |  | ther's Name <i>(First,</i><br>de I. For      |                              | in Sumame)               |   |
| Ž          | 2 should<br>and Me<br>is mark<br>sumation  | <sup>L</sup>   | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Numb  |  |                              | or Town, State,          | Zip Code)   |
|            | Tand 2<br>Health a<br>tam 27 is  |                | Mitchell E. Meyers/Son 202 Beaumont Ave.   | Catonsvi                                     | ille MD                      | 21228                    |   |
| ore        | ges 1<br>t of He<br>If itan<br>or oth  |                | 20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Removal from State  Bayvae Crematory or other place)  Bayvae Crematory  | Date 12-28-20                                |                              | Location - City o        |   |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Manjar Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "netural; or itams 23a or 28e-f show any njury or other traumatic event, the Medical Exant at mast be rediffied at once. |                | *4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee 22. Name and Address of Faci  |  | 703 Bul                      | cimore,                  | TID   |
| Ba         | Department of the police once  |                | Ambrose Funera   | al Home,<br>Spring Rd                        | Arhu                         | tue MD                   | 21227   |
|            |  |                | 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line.  | as cardiac or respir                         | atory arrest,                |                          | Approximate<br>Interval Between                     |
|            | Physician  |                | Immediate Cause (Final disease or condition resulting in death)  a. RESPIRATORY FAILURE  |  |                              |                          | Onset and Death                                     |
| L          | /Medical<br>Examiner   |                | Due to (or as a consequence of):   | STRESS                                       | SYNN                         | enme                     | 16 House  |
|            |  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):   | -11-0-3                                      | - (1-0                       | Rome                     | 19 110045   |
| /          | ecuted<br>and<br>-transi   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):   |  |                              |                          | 3 DAYS.   |
| 68760,     | eath certificate be executed attending physician and for use as the burial-transit   | ical E         | Due to (or as a consequence or).   |  |                              |                          |   |
|            | tificate<br>og phys<br>as the  |                | 0.   |  |                              |                          |   |
| Вох        | death certifics<br>e attending pt<br>id for use as ti  | an/N           | IFFEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  |  |                              | 23d. Date of de<br>Month | elivery<br>Day Year                                 |
| P.O. E     | 0 0  | Physician/Med  | 1 ☐ Yes 2 12 140 4 ☐ Pregnant at time of death 5 ☐ Other (specify)<br>9 ☐ Unknown 9 ☐ Unknown  |  |                              | Worth                    | Day (Gal  |
| s, P.      | requires that the<br>been signed by th<br>hould be detache   | by Ph          | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part  | rt I. 236                                    | e. Did tobacco               | use contribute           | to the cause of death?                              |
| ords       | w require<br>been sig<br>should b  |                | DIABGRES MGULINS TYPE 2.   |  | 1 🗆 Yes                      | 2 🗹 No 3 🗆 P             | robably 4 Unknown                                   |
| Record     | aw<br>Is t   | Completed      | Acure Anomia   | 248  | a. Was an<br>autopsy         | prior to                 | utopsy findings available<br>completion of cause of |
| al F       | Th<br>ate<br>pag   |                | Conacerne HEART FAILURE.   |  | performed? Yes 2 N           |                          | s 2 No  |
| Vital      | Physician: this certific   | To Be          | avaminar?  | ice of Death <i>(Check</i><br>Nursing Home 5 |                              | 6 □Other (Sp.            | ecify)  |
| n of       |  |                | 27. Manner of Death 1 ✓ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of lnjury at lnjury Work?  |  | scribe how int               |                          | ,,  |
| Division   | Attanding r death. actor: After  | catl           | 2 Accident investigation M 1 Yes 2   |  | ostion (Ctroot               | and Alumbar of E         | Pumi Pauta Alumbar                                  |
| DΙΧ        | or A<br>tter<br>Sirac<br>in by   | Certification: | 4 ☐ Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  | City   | y or Town, Sta               | te)                      | iural Route Number,                                 |
|            | To the Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the   |                | 29a. Certifler (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, de  | and place, and due                           | to the cause(                | s) and manner a          | s stated.   |
|            | the H  | Medical        | and manner stated.  29b. Signature and title of certifier  29c. License number   |  |                              | ate signed (Mon          | ``  |
|            | 5 <u>₹</u> 5 8   | _              |  |  |                              |                          |   |
|            | 1  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  | بالمار المار                 | -, 26                    | , 2005-<br>M, mg 21042                              |
|            | 1  |                | SABA SHEKH M.O. 9057 BALTIMORE NATIONAL KIN  | LC STE                                       | 4C, Eu                       | ucon Ci                  | M. mg 21642   |
|            | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) DEC 3 0 2005   |  |                              |                          |   |
|            |  | - 4            | The state of the s |  |                              |                          |   |

State of Maryland / Department of Health and Mental Hygien Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** NOWAKOWSKI, Tephen 2 40 AM 8, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMERE YARKUILLE NYDER LANC If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months 213-09-877 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iteme 23a or 28s-f ehow any injury or other traumatic event, Ita Medical Evantmer must be notified at ODEs. 10c. City, Town or Location 10d. Inside City Limits 10a. State MD YARKUIlle 1 Yes 2 No BALTIMORE Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9412 SNY DER 21234 U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 0.5. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married \_2 Married Maryland 21215-0036 1 ☐ Yes 2 No if Yes, Give Year or Dates: Specify: While þ 3 Widowed 4 Divorced ARMY Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 121 CHRK (100) Chain NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NOWAKOWSKI MARY UNKNOWN INCENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9412 SNYDER LANE, BAItO. MI 21234 NOWAKOWSKI, JR ephen Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date → Bunal 2 Cremation 3 Removal from State 131/05 SACTER BAlto. MD. Lear Tof Jesus 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HARTLEY MillER- STELLA
7527 har Ford RD. Balto. 21. Signature of Funeral Service Licensee FUNELAI HOME CHTO. Bulto. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequer Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physicien and d be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 No of Vital To the Hoepital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certifice Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) To the Funaral Diractor: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No М 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CAMPbell 4920 Nishi BLUD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

|     |   |     | -   | 2 |
|-----|---|-----|-----|---|
|     | 9 | -1  | (C) | 1 |
| 1.5 | 1 | - 1 | 7   | Ь |

Baltimore, Maryland 21215-0036

Nelson, William

Division of Vital Records, P.O. Box 68760,

|   |                | 1 - State<br>Registrar   |   | ,            | Cer                        | tificate of                            | Death                                    | F  | ZUU               | 0 42134  |
|---|----------------|--|---|--------------|----------------------------|--|--|--|-------------------|--|
| 437   |                | 1. Decedent's Name (First, Middle, Last  | )   |              |                            |  | -  | 2. Date of Dea   | ith               | 3. Time of Death   |
| Physicia<br>/Medic  |                | William H. Nelson  |   |              |                            |  |  | Decembe  | Day 26 2          | Year 3:00 M  |
| Examine   |                | 4a. Facility Name (If not institution, give  | street and number)                              |              |                            | 4b. City, Town, o                      | or Location of Dear                      | th   | 4c. County        | of Death   |
|   | а              | Bullinge Washing   | ton Medicu                                      | 1 Cen        | ter                        | Glen                                   | Burnie                                   |  | Anne              | Arondel  |
| Funeral<br>Director   |                | 5. Social Security Number 6. Se  | 7. Age<br>M 2□ F                                | (In yrs. la  | st birthday)<br>Yrs.       | If Under 1 Year<br>Months Days         | If Under 24 Hrs<br>Hours Min.            |  | Year              | 9. Birthplace (State or Foreign<br>Country)<br>Minnesota |
| ַם  | Ì              | Usual Residence of Decedent  |   |              |                            |  |  | pair. Ji   | , 1004            | Himesota   |
| rylan<br>how  |                | 10a. State 10b. County   |   | 10c. City,   | Town or Lo                 | cation                                 |  |  |                   | 10d. Inside City Limits                                  |
| a Ma  | cto            | Maryland Baltimore   | e City  | Balt:        | imore                      |  |  |  |                   | 1X Yes 2 No  |
| or 28   | Director       | 10e. Street and Number   |   |              |                            | 10f. Zip Code                          |  | 1  | l0g. Citizen of W | hat Country?   |
| 23a   |                | 2553 Southdene Ave   | e .   |              |                            | 21230                                  |  | 1  | Jnited S          | tates  |
| dea   | Funerai        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?             | er in U.S    | . 13. V                    | Vas Decedent of H                      | lispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or No-   | 14. Race          | - American Indian,                                       |
| urs a   | þ              | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced                             | 1 ☐ Yes 2 📉 N<br>If Yes, Give<br>Year or Dates: | lo           |                            | ☐ Yes 2X No                            | Specity:                                 | to rican, etc.)  |                   | white, etc. White  |
| 2 ho  | Completed      | 15. Decedent's Edu   | cation  |              | 16a. Deced                 | ent's Usual Occup                      | pation                                   |  | 16b. Kind of Bus  |  |
| hin 7   | pie            | (Specify only highest grade<br>Elementary/Secondary (0-12)                         | e completed) College (1-4or 5                   | 4)           | (Give i<br>life. D         | kind of work done<br>OO NOT use retire | during most of wo<br>d)                  | rking  |                   | ,  |
| d witi  | E              | 12   | College (1°401 3                                | +)           | Truck                      | Driver                                 |  |  | Transp            | ortation   |
| othe<br>othe  | Bec            | 17. Father's Name (First, Middle, Last)  |   |              |                            |  | 18. Mother's Na                          | me (First, Middle, I   |                   |  |
| Aenta h   | 10             | Duane Nelson   |   |              |                            |  | Doroth                                   | y Turner   |                   |  |
| should have   |                | 19a. Informant's Name/Relationship (Ty   | rpe, Print)                                     |              | 19b. Mailin                | g Address (Street                      |  |  | , City or Town, S | State, Zip Code) 21060                                   |
| elith a   |                | Lesia Y. Nelson /  | Wife  | Ė            |                            |  |  |  |                   | len Burnie, MD   |
| othe  |                | 20a. Method of Disposition   |   | 20b. Pla     | ce of Dispos               | sition (Name of patory or other place  |  | A STATE OF THE PARTY OF THE PAR |                   | City or Town, State                                      |
| Page<br>Bent c  | į              | 1 ☐ Burial 2 X Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)                 |   | 1            |                            | matory                                 | · 1                                      | 31, 2005   | Caton             | sville, MD   |
| mit.  |                | 21. Signatur Funeral Service License   |   | 11001        |                            |  | ss of Facility                           | J1, 200_   | Gaton             | sville, m  |
| Depa<br>Impo<br>any I   |                | Au L. Etc  | augh  |              | K                          | irkley-R                               | uddick F                                 | uneral Ho  | ome, P.A          | MD 01061   |
|   |                | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or      | ications that caused                            | the death.   | Do not ente                | r the mode of dyir                     | nwy . S .<br>ng, such as cardia          | or respiratory arm   | Burnie,           | MD 21061 Approximate                                     |
| Physician   |                | Immediate Cause (Final   |   |              |                            |  | A .                                      |  |                   | Interval Between<br>Onset and Death                      |
| /Medical  |                | disease or condition resulting in death)   | Due to (or as a                                 |              |                            | wices                                  | neu                                      | norrha   | 25-               | 1 day  |
| Examiner  |                |  | Due to (or as a                                 | · · V        | 1                          | 515                                    |  |  |                   |  |
|   | er             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a                                 |              |                            | 77()                                   |  |  |                   | 46082  |
| dansit  | Examiner       | Cause. Enter Underlying Cause (Disease or injury that initiated events             |   |              |                            |  |  |  |                   |  |
| be executed ician and burial-transit  | Exa            | resulting in death) Last   | Due to (or as a                                 | conseque     | nce of):                   |  |  |  |                   |  |
| ertificate be executed<br>ling physician and<br>e as the burial-transit                         | ca .           |  | 1.  |              |                            |  |  |  |                   |  |
| ding physics as the t   | Medical        |  |   |              |                            |  |  |  |                   |  |
| 0 0 0   |                | IF FEMALE:<br>23b. Was decedent pregnant   | 3c. If yes, outcome of                          | of pregnance | у                          |  |  |  | 23d. Date         | of delivery  |
| death c   | Physician      | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1 Live birth 2<br>4 Pregnant at t               |              |                            | Ectopic pregnancy<br>Other (specify)   |  |  | Mont              |  |
| by the a  | nys            | 9 Unknown  | 9□ Unknown                                      |              |                            |  |  |  |                   |  |
| es tha<br>gned<br>be det  | 7              | Part II. Other significant conditions con  | tributing to death bu                           | t not result | ing in the un              | derlying cause giv                     | en in Part I.                            | 23e. Did tob   | acco use contrib  | oute to the cause of death?                              |
| The law requires that the death ate has been signed by the atterpage 2 should be detached for u | D              | Depres   | Sion  |              |                            |  |  | 1 🗌 Ye   | s 2 🗆 No 3        | ☐ Probably 4 ☐Unknown                                    |
| s been si   | Completed      | _ 0  |   |              |                            |  |  | 24a. Was ar  | 24h W             | ere autopsy findings available                           |
| The law<br>cate has l   | Ĕ              |  |   |              |                            |  |  | autops   | y pri             | or to completion of cause of ath?                        |
| icien: Th<br>certificate<br>rector, pag   |                | 25. Was case referred to medical   |   |              |                            |  |  |  | No 1              | Yes 2 No   |
| sicien;<br>certific<br>lirector,  | o ne           | examiner?  | ospital:  |              | 2/0                        | 3 DOA Oth                              |  | th Check only one  |                   |  |
| Phys<br>raldi   | - 1            | 27. Manner of Death  | 1 Aunpatier<br>28a. Date of Injury              |              | NOutpatient<br>8b. Time of | 30 DON                                 | 4 Linutsing n                            | ome 5 Reside   |                   |  |
| ding f<br>h.<br>After<br>funer  |                | 1/SNatural 5 ☐ Pending<br>2 ☐ Accident investigation                               | (Month, Day                                     | Year)        | Injury                     | 28c. Injun<br>Worl                     | k?<br>Yes 2 □ No                         | Est. Boscillo ilo  | w injury occurred |  |
| or Attending Physicien: ifter death Director: After this certific in by the funeral director,   | <u> </u>       | 3 Suicide 6 Could not be   | 28e. Place of Injur                             | rv - At hom  | e farm stre                |  | 700 2 1100                               | 28f Location (St   | root and Number   | or Rural Route Number.                                   |
| after death<br>after death<br>Director:   | Certification: | 4 Homicide determined  | building, etc.                                  | (Specify)    | o, .a, o                   | ot, ractory, office                    |  | City or Town   | , State)          | or Aurar Aoute Wolfiper,                                 |
|   |                | 29a. Certifier 1 Certifying Phys   | sician: To the best of                          | my knowle    | edge, death                | occurred at the tim                    | ne, date and place                       | and due to the ca  | use(s) and manr   | ner as stated.   |
| n 24<br>he Fu   | Medical        | (Check only 2 Medical Examinate)   | ner: On the basis of and manner stat            | examinatio   | n and/or inve              | estigation, in my o                    | oinion, death occu                       | rred at the time, da   | ite and place, an | d due to the cause(s)                                    |
| To the within 2 To the complet  | Ξ              | 29b. Signature and title of certifier  | 10  |              |                            | 29c. License                           | number                                   | 29   | d. Date signed (  | (Month, Day, Year)                                       |
|   |                | ( holes >  | lever   | au           | (1)                        | D                                      | 3428                                     | 7.   | Deris             | Cor 26 2005  |
| 2   |                | 30. Name and address of person who co  | mpleted cause of de                             |              |                            |  | V1-8 E                                   | وعدا، تعا  | ull in i          | Ger 26 2005<br>S Glen                                    |
| 0   |                | Boltimore Was  |   |              | edica                      |  | -or 30                                   |  | -1 Drive          |  |
|   |                | 24 Date 61ad (16 ath Da 16 a 1   |   |              |                            |  |  |  |                   |  |

Registrar

DEC 3 0 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Okerblad :15 PM **Physician** December EdVIN 20,2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Johns Hopkins Bayview Medical Center N/A If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Months Hours Min. 1 M 2□F 214-24-8641 91 Director Nov. 3,1914 Estonia, Sweden Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location or 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23s or 28s-1 ehov other traumatic event, tra Mexical Examiner must by notified at 1 ☐ Yes 2 ☑ No Dundalk Baltimore Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21222 United States 7920 Lansdale Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event. The account of the page 2000. 1 ☐ Yes 2√☐ No ff Yes, Give Year or Dates: 1 Never Married & Married 1 Yes 2 KNo Specify Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coifege (1-4or 5+) Merchant Marine Merchant Shipping Ukn 18. Mother's Name (First, Middle, Maiden Sumame) Unkn. 17. Father's Name (First, Middle, Last) Be Ukn. Okerblad ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7920 Lansdale Road Dundalk, Maryland Mrs. Teruko Okerblad (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 12/30/2005 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner AUREUS BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding in death). Last Due to (or as a consequence of): Examine use as the burial-transit resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medicai IF FEMALE: 23c. ff yes, outcome of pregnancy 1☐Live birth 2☐Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 ☐Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ۵ 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Naturat Infury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, death. within 24 hours after death To the Funeral Director: completely filled in by the ş

> State Registrar

Medicai

4 🗌 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

Year) 31. Date filed (Month.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

MAKYY \_, GOI NORTH CAROLINE STREET, BALTIMORE

29d. Date signed (Month, Day, Year)

)ecember 20 , 206S

1-Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

|  |  | 1           | For<br>State<br>Registrar  | State of I  | Marylar            | •                                       | artmen<br><i>tificat</i>       |                    |  | Mental Hy                            | giene<br>Reg. No           |                  | 5 L                           | 2196   |
|--|--|-------------|--|---|--------------------|---|--------------------------------|--------------------|--|--------------------------------------|----------------------------|------------------|-------------------------------|--|
|  | hysiciar   |             | 1. Decedent's Name (First, Middle, La.   | st)   |                    |   |                                |                    |  | 2. Date of D<br>Month                | eath<br>Dav                | Y                | Year _                        | 3. Time of Death                                   |
|  | /Medica<br>xamine  | i -         | BARBARA ANN  4a. Facility Name (If not institution, given  | PAYNE<br>e street and number  | 9r)                | 1                                       | 4b. City,                      | Town, or           | Location of Dea                        | Decem                                |                            | County of        | 2005<br>of Death              | 8:56 AM  |
|  | jilijaja 4   | £81         | Good Samarit   |   | Spi                | tal                                     | Ba<br>If Under                 | 150                | NOVE<br>If Under 24 Hrs                |                                      |                            | NA               | 2.51                          |  |
|  | neral<br>ector   |             | 5. Social Security Number 6. S<br>227-66-0716  | ex<br>□ M 2/CXF   |                    | last birthday)<br>59 Yrs.               | Months                         | Days               | Hours Min                              |                                      | lay, Year)                 | 16               | Counti                        | ace (State or Foreign<br>y)<br>GINIA               |
| and  | A T  | -           | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. Ci            | ity, Town or Lo                         | cation                         |                    |  |                                      |                            |                  | 10                            | d. Inside City Limits                              |
| Mary   | 28a-f ehow   | 2           | MARYLAND N/A   |   |                    | F                                       | BALTI                          | MORE               |  |                                      |                            |                  |                               | 1∏Yes 2☐No   |
| with the   | by notified  |             | 10e. Street and Number   |   |                    |   | 10f. Zip                       |                    |  |                                      |                            |                  | /hat Count                    | ry?  |
| M  | or itams 23a   | G           | 5614 CLEARSPRIN  11. Marital Status  | 12. Was Decede  |                    | J.S. 13.                                | Was Deced                      | 212.<br>dent of Hi |  | Specify Yes or N<br>rto Rican, etc.) |                            |                  | - America                     |  |
| 100 PV PP 1215-0036 within 72 hours after death with the Maryland                | st, or items 23s or 28s-f eho<br>Exertitet ritist by notified at | n A         | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ※ Worced  | Armed Force 1 Yes 2 If Yes, Give                                    | No                 | -                                       | 1 Yes, spec<br>1 ☐ Yes         |                    | n, мехісап, Рив<br>Specify:            | no Hican, etc.)                      |                            |                  | k, White, e<br>BLA            |  |
| 7 6 5-0036 72 hours at   | - Table -  | ם ב         | 15. Decedent's Ed  |   | S:                 | 16a. Dece                               |                                |                    |  | orking                               | 16b. K                     |                  | siness/Indi                   |  |
| Ann 21215-( 30 within 72 h   |  | E L         | (Specify only highest gra  | College (1-4d   | or 5+)             | life. I                                 | DO NOT us                      | se retirea         |  | orking                               | 277                        | TD (7 = 1)       |                               |  |
| Hyging C   |  |             | 12th grade  <br>17. Father's Name (First, Middle, Last,  | 2yrs +  |                    | REGIS                                   | TEREI                          | ) NUI              |  | me (First, Middl                     |                            | JRSIN<br>Sumame  |                               |  |
| Marylanc 2 should be to and Mental by  | 9 • 4  | 0           | GEORGE N. BOOKER   | 2   |                    |   |                                |                    | SARAH                                  | B BOOKE                              | R EGG                      | LEST             | ON                            |  |
| Maryland of the and Mental Hy  | P =  | 1           | 19a. Informant's Name/Relationship (   |   | D l-               | 1                                       |                                |                    |  | Rural Route Num                      |                            |                  |                               |  |
| To a   | item 2<br>other  | -           | Antionette C. Di   |   | 20b.               | T⊜Y<br>Place of Dispo<br>cemetery, cren | sition (Nan                    | ne of              |  | Rd., B                               |                            |                  | City or Tow                   |  |
| Baltimore,   | tant: If   |             | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)  | y)  |                    | ING MEM                                 |                                |                    |  | 30-05                                |                            |                  |                               | ARYLAND  |
| Baltimore permit. Pages 1 Department of H  | any in   |             | 21. Signature of Funeral Service Licer   | 1   |                    |   |                                |                    | is of Facility<br>BROWN CC<br>TH AVENU | MMUNI <b>TY</b><br>JE                | FUNE                       | ERAL             | HOME                          | P.A.   |
| /Me  | sician<br>edical<br>miner  |             | 23å. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. mc   |                    | and                                     | er the mod                     | _                  |  | ac or respiratory                    |                            |                  |                               | Approximate<br>Interval Between<br>Onset and Death |
| <u> </u>   | sit sit  | 2           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | b. Directo (or  | de di diunes.      | quariou of):                            |                                |                    |  |                                      |                            |                  |                               |  |
| 8760,  | chysician and the burial-transit                                 |             | Cause (Disease of Injury<br>that initiated events<br>resulting in death) Last  | c. Due to (or   | as a conse         | quence of):                             |                                |                    |  |                                      |                            |                  |                               |  |
| Box (  | d by the attending physicilletached for use as the bu            | iysiciaiume | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcor<br>1 □ Live birth<br>4 □ Pregnan<br>9 □ Unknowr | 2 ☐Fetat time of   | al death 3                              | Ectopic pr<br>Other <i>(sp</i> |                    |  |                                      |                            | 23d. Date<br>Mon | of deliver                    | y<br>Day Year                                      |
| US, P  | be d   | 2           | Part II. Other significant conditions of   | ontributing to deat   | h but not re       | sulting in the u                        | nderlying c                    | ause give          | on in Part I.                          |                                      | tobacco u                  | _                | bute to the                   | cause of death?                                    |
| COL.   | age 2 should l   | alaic       | Diobedes   |   |                    |   |                                |                    |  | 24a. Wa                              | รลก                        | 24b. W           | /ere autop:                   | - ti-da-a avadabla                                 |
| F F F  | 0 Q (  |             |  |   |                    |   |                                |                    |  | auto<br>peri<br>1 Yes                | opsy<br>formed?<br>2 14 No | de<br>1          | rior to com<br>eath?<br>Yes 2 | sy findings available pletion of cause of          |
| Vita   | ertific<br>actor,  | מ           | 25. Was case referred to medical examiner?   | Hospital:   |                    | <b>F</b> ED 10                          |                                | Othi               |  | eath (Check only                     |                            |                  |                               |  |
| g Phys   | After this c<br>funeral dire                                     |             | Yes 2 □ No<br>27. Manner of Death  | 28a. Date of I  |                    | ER/Outpatien<br>28b. Time of<br>Injury  |                                | 8c. Injun<br>Work  | 4 🗆 Iduising                           | Home 5 Res                           |                            |                  |                               |  |
| Division of Vital Records, to Attending Physician: The law requires tales death. | irector:<br>in by the  | erillicatio | Natural 5 Pending investigation 3 Suicide 6 Could not be determined  | e 28e. Place of   |                    | nome, farm, str                         | М                              | 1 🗀 '              | res 2 □No                              |                                      | (Street an<br>own, State   |                  | or Rural                      | Route Number,                                      |
| To the Hospital within 24 hours a  | Funeral E  | E C         |  | ysician: To the be  | s of examin        |   |                                |                    |  |                                      |                            |                  |                               |  |
| To the   | To the Fun<br>completely   | Medi        | 29b. Signature and title of certifier  | and manner  | Stated.            | icica                                   | Ì                              | License            | 1920                                   | 140                                  | 10                         | 2/2              | (Month, D                     | 55   |
| -  | 6  |             | 30. Name and address of person who   | completed cause of  | of death (Ite      | m 23a) (Type,                           |                                | · -                | 21/1                                   | baltim                               | 0.1-0                      | M 0              | 110                           | 1 20   |
|  | State  |             | 31. Date filed (Month, Day, Year)  | 32. Reg   | O \ listrar's Sign | ature A                                 | MAVE                           | W,                 | BIVA, 1                                | JUU IIM                              | Urki                       | (V( I)           | 4                             | -7   |

UNK 05-08654 d1

Please Type or Print in Black Indelible lak TEnsure All Copies Are Legible. Amend Unpend item#1,23a,27,28a-f,pen/E,332,2/2/06 Handle and Mantal Haring. Amend item#23a, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Shannon E. Pickett Day **Physician** Month December 22. 2005 5:31 SHANNON E PIKETT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 301 McCann Street Edgewood Harford If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F Yrs Director 215-90-1621 29 OCT 10 1976 MARYLAND Usual Residence of Decedent the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND HARFORD CO **EDGEWOOD** Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other than "natural", or items 23s or sent, the Medical Examiner must be 606 LAKE AVENUE death 21040 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 2 XX o If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12yrs WAITRESS 2vrs FOOD SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) i. Pages 1 and 2 should be fil itment of Health and Mental H riant: If Itam 27 is marked oth ijury or other traumatic ever JACKIE WAYNE PICKETT SR SHARI BETH BALDWIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shari Baldwin/Mother 606 LAKE AVENUE, EDGEWOOD, MARYLAND 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page Depertment of Important: If any Injury or once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 12-30-05 BALTIMORE, MARYLAND 21. Signature of First ral & Licenson 22. Name and Address of Facility
WM C BROWN COMMUNITY FUNERAL HOME-HARFORD,
321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 LAUUU Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cocaine and Narcotic (methadone) intoxication Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cocaine Intexication Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **☐**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

129 Yes 2□ No 24a. Was an certificete has b irector, page 2 s 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence MOther (Specify, Hospital: 1 ☐ Yes 2 ☐ No spital: 1 Inpatient 2 EP/Outpatient 3

28a. Date of Injury (Month, Day Year) 28b. Time of Injury DOA 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2X No investigation 4:00 A 2 Accident 6 X Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 301 McCann Street 4 Homicide Found at residence Edgewood, MD 21040 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier **OCME** December 22, 2005 30. Name and address of person who completed cause death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 THEOWRE Milling 31. Date filed (Month, Day, Year)

State Registrar

DEC3 0 2005 32. Registrar's Signature

Box 68760.

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Records.

Division of Vital

Records, P.O.

0345AN

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 3:45 AM Valerie Rose AKA Valery Rose December 30, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☐ M 2 🗹 F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Yrs. 59 Director 080-36-6750 03/15/1946 NY Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits traumatic evant, the Medical Exeminer must be notified at 1 Yes 2 No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 8507 Falls Run Road Apt. K 21043 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NDT use retired) Own Home College (1-4or 5+) filed within Hygiene. Elementary/Secondary (0-12) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental h Theresa Miraglia George Rex 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an Gregory Rose/Husband 8507 Falls Run Road Apt. K Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
important: If ite
any injury or ott 1 ☐ Burial 2/ESCremation 3 ☐ Removal from State Dec 30 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2005 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lenda Sue Retter Cremation and Funeral Alternatives Molyus 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. En + r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ocular melanama Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed' 2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 4 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Naspice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Natural Natural 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 58303 December 30 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 N. Charles St RATIMOZE MO ZIZON CHARLES un Amon 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 3 0 2005 State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

|            |  |                  | 1 - State Registrar Amend ITem  1. Decedent's Name (First, Middle, Las     | State of I                                | -                   |                                  |             |                              |                 |           | lental      |                       | ne (        | )5                     | 42199  |
|------------|--|------------------|--|---|---------------------|----------------------------------|-------------|------------------------------|-----------------|-----------|-------------|-----------------------|-------------|------------------------|--|
| 6          | Physici  | an               | Decedent's Name (First, Middle, Lass  EVELYN MARI                          |   |                     | <del>/1 1/1</del>                | 7,00        | OIL                          |                 |           | Montl       | of Death<br>n<br>mber | 29          | Year<br>2005           | 3. Time of Death                               |
| 100        | _/Medio  |                  | 4a. Facility Name (If not institution, give                                |   |                     |                                  | 4h Cit      | , Town, or                   | Location        | of Death  | Dece        | IIIDET                |             | ty of Death            | 12:45 p <sup>M</sup>                           |
|            | Examir   | er               | Hillhaven  | Street and numb                           | <i>61)</i>          |                                  |             | elphi                        |                 | OI DBalli |             |                       |             | •                      | orge's   |
|            | ž  | (4 °)            | 5. Social Security Number 6. S   | 7   | Ann (In vrs         | last birthday)                   |             | er 1 Year                    | If Under        | 24 Hrs.   | 8. Date     | of Ridh               | PLIII       |                        | Place (State or Foreign                        |
|            | Funeral  |                  |  | ∩ M 2 D F                                 |                     | Yrs.                             | Month       |                              | Hours           | Min.      | (Mont       | h, Day, Y             |             | Cou                    | ntry)  |
|            | Director   |                  | 200-28-3863 Usual Residence of Decedent                                    | XX  | 91                  |                                  |             | 1                            |                 |           | Apr.        | 3,                    | 1914        | Pen                    | nsylvania                                      |
|            | and  |                  | 10a. State 10b. County   |   | 10c. Ci             | ty, Town or Lo                   | calion      |                              |                 |           |             |                       |             | 1                      | Od. Inside City Limits                         |
|            | Aaryl<br>- hc  | ō                | MD Prince  | George's                                  | Т                   | aurel                            |             |                              |                 |           |             |                       |             |                        | 1 ☐ Yes 2 ☑ No                                 |
|            | 28a-   | ect              | 10e. Street and Number   |   |                     | aut ci                           | 10f 7       | ip Code                      |                 |           |             | 100                   | Citizon of  | f What Cour            |  |
|            | within 72 hours after death with the Maryland<br>ane.<br>then "naturel", or items 23a or 28a-f ehow<br>he Madical Examilier must be notified at  | Funeral Director | 15917 Jerald Road  |   |                     |                                  |             | 0707                         |                 |           |             |                       | U.S.A       |                        | my:  |
|            | s 23   | ral              |  | 12. Was Decede                            | at Cuasia II        | 10 12                            |             | edent of H                   |                 | -in2 /Cn  | andu Van    |                       |             | ace - Americ           | an Indian                                      |
|            | er de  | n                | 11. Marital Status   | Armed Force                               | s?                  | 13.                              | If Yes, sp  | ecify Cuba                   | n, Mexicai      | n, Puerto | Rican, etc  | 0.)                   |             | ack, White,            |  |
| 36         | s aft  | by F             | 1 ☐ Never Married 2 ☐ Married  3XXWidowed 4 ☐ Divorced                     | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Date |                     |                                  | 1 🗆 Yes     | <b>2XX</b> No                | Specify:        |           |             |                       | Spec        | ity: Wh                | ite  |
| 21215-0036 | hour<br>turel  | De la            | 15. Decedeni's Ed  |   |                     | 16a. Dece                        | donl's lis  | ual Occup                    | ation           |           |             | 16                    | b Kind of   | Business/In            | ductor   |
| 5          | n 72   | Completed        | (Specify only highest gra  | de completed)                             |                     | (Give                            | kind of v   | ork done o                   | during mos      | t of work | ing         | 10                    | b. Kind of  | Dusiness/in            | dustry   |
| 12         | within sne.  | E .              | Elementary/Secondary (0-12)  | 1 years                                   | or 5+)<br>S         | 1                                |             | de As                        | ´ .             | ant       |             |                       | Denta       | 1                      |  |
|            | Hygier III.  |                  | 17. Father's Name (First, Middle, Last)                                    |   |                     | 1                                |             |                              | 18 Moth         | ar's Name | (First, M   | iddle Ma              | iden Suma   | ame)                   |  |
| Maryland   | od o   | Be               | John L. O'Connell  |   |                     |                                  |             |                              |                 | a Kir     |             |                       |             |                        |  |
| 2          | d Me   | L<br>L           |  | Comp. (Print)                             |                     | 10h Maili                        | - Addes     | (Chana)                      |                 |           |             |                       | Oh a Tau    | - Canala 7:-           | - 0-4-1  |
| <u>a</u>   | 12 st  |                  | 19a. Informant's Name/Relationship   |   | ah+or               |                                  | _           | rald                         |                 |           |             |                       | -           | n, State, Zip          |  |
|            | l and<br>teatt   |                  | Nancy Ann Gotshal  | l / dau                                   |                     | Place of Dispo                   |             |                              | ROAG            |           | Date        | _                     | yland       |                        |  |
| 9          | i of h   |                  | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 🗶                    | Removal from Sta                          |                     | cemetery, crei                   | natory of   | other plac                   | e)              |           | Jate        | 20                    | c. Location | - City or To           | own, State                                     |
| Ξ          | Pag<br>ant:<br>ury   |                  | 4 □Donation 5 □ Other (Specify   |   |                     | lvary                            | Ceme        | tery                         | 1               | 1/4/2     | 2006        | A                     | ltoon       | a, PA                  |  |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other traumatic event. The Madical Examiner must be notified at ODGs. |                  | 21. Signalure of Funeral Sovice Licen                                      |   | M00770              |                                  |             | and Address<br>dson<br>albot |                 |           |             |                       | Mary        | land                   | 20707  |
|            |  |                  | 23a. Part1. Enler the disease, o com<br>shock, or heart failure. List only | olications that cau                       | sed the deat        | th. Do not ent                   | ter the m   | de of dyin                   | g, such as      | cardiac o | or respiral | ory arrest            |             |                        | Approximate<br>Interval Between                |
|            | Physician  |                  | Immediate Cause (Final   |   |                     | ular A                           | aaid        | ont /                        | Ctr             | ak o      |             |                       |             |                        | Onset and Death 7 days                         |
| 19/2       | /Medical   |                  | disease or condition resulting in death)                                   | a   | as a conseq         |                                  | CCIU        | ent /                        | SCIO            | JKE       |             |                       |             | -                      | / days   |
|            | Examiner   |                  | - 1  |   | tensio              |                                  |             |                              |                 |           |             |                       |             |                        |  |
|            |  | e                | Sequentially list conditions, if any, leading to immediate                 | D   | as a conseq         |                                  |             |                              |                 |           |             |                       |             |                        |  |
| <b>V</b>   | ted  | Examlne          | cause. Enter Underlying<br>Cause (Disease or injury                        |   |                     |                                  |             |                              |                 |           |             |                       |             |                        |  |
| •          | icate be executed<br>physician and<br>s the burial-transit   | xar              | that initiated events resulting in death) Last                             | c Due to (or                              | as a conseq         | quence of):                      |             |                              |                 |           |             |                       |             |                        |  |
| 8760,      | be e<br>ician<br>buris   | alE              |  |   |                     |                                  |             |                              |                 |           |             |                       |             |                        |  |
| 87         | phys<br>the  | dical            | •  | d   |                     |                                  |             |                              |                 |           |             |                       |             |                        |  |
| 9          | that the death certific<br>ed by the attending p<br>detached for use as  | (D)              | IF FEMALE:   | 22a If was outco                          | mo of progn         | 2021                             | ×.          |                              |                 |           |             |                       |             |                        |  |
| Вох        | ath c  | lan/             | 23b. Was decedent pregnant in the past 12 months?                          | 23c. If yes, outco                        | n 2 ∏ Feta          | aldeath 3[                       |             | pregnancy                    |                 |           |             |                       |             | ate of delive<br>Month | ery<br>Day Year                                |
|            | the a  | slc              | 1 ☐ Yes 2 🖾 No<br>9 ☐ Unknown  | 4□Pregnan<br>9□Unknow                     |                     | death 5                          | Other (     | specify)                     |                 |           |             |                       |             |                        |  |
| P.O        | d by<br>etacl  | Physician/M      |  |   | b b                 |                                  | - 1 1 1     |                              | 1. 5            |           | 00-         | Didash                |             |                        |  |
|            | 89 G 60  | þ                | Part II. Other significant conditions of                                   | ontributing to deat                       | n but not res       | suiting in the u                 | naeriying   | cause give                   | en in Parti     |           | 230.        |                       |             |                        | he cause of death?                             |
| Records,   | w requir<br>been si<br>should  | Completed        |  |   |                     |                                  |             |                              |                 |           |             | 1 Yes                 | 2 🔀 🏋 ○     | 3∐ Prot                | oably 4 Unknown                                |
| 900        | aw r<br>as be<br>2 sh  | ple              |  |   |                     |                                  |             |                              |                 |           | 24a.        | Was an autopsy        | 24b         |                        | psy findings available<br>mpletion of cause of |
| m          | The tree has age   | E                |  |   |                     |                                  |             |                              |                 |           | 101         | performe              | d?<br>No    | death?                 | 2 <del>(2)</del> No                            |
| Vital      |  | 0                | 25. Was case referred to medical   |   |                     |                                  |             |                              | 26. Place       | of Deatl  | n (Check    |                       | X           |                        | -XX  |
| >          | Physician:<br>this certific<br>ral director,   | O.B              | examiner?<br>1 Tes 247No   | Hospital: 1 □ Inp                         | atient 2            | ER/Outpatier                     | nt 3 🗆 t    | Oth                          | өг: <b>4</b> ХХ | ursing Ho | me 5        | Residence             | e 6 □O      | ther (Specif           | v)   |
| o          | g Phys<br>er this<br>eral di   | n: T             | 27. Manner of Death  | 28a. Date of                              | Injury<br>Day Year) | 28b. Time o                      | f           | 28c. Injun<br>Worl           |                 |           |             |                       | injury occu |                        |  |
| O          | ith.<br>:: After   | # 10             | 1 X atural 5 ☐ Pending<br>2 ☐ Accident investigation                       |   | Day (Gai)           | Injury                           | М           |                              | Yes 2           | No        |             |                       |             |                        |  |
| Division   | Attending r death. ector: After by the fune  | ‡ C              | 3 ☐ Suicide 6 ☐ Could not be   | 288. Place of                             | Injury - At h       | ome, farm, sti                   | reet, facto | ory, office                  |                 |           | 28f. Locat  | ion (Stre             | et and Num  | ber or Rura            | I Route Number.                                |
| Dİ         | efter<br>Olive<br>d in b   | Certification:   | 4 Homicide   | building                                  | , etc. (Specia      | ry)                              |             |                              |                 |           | City o      | or Town, s            | otate)      |                        |  |
|            | To the Hospital or Attending I within 24 hours efter death.  To the Funeral Director: Atter completely filled in by the funer  |                  | 29a. Certifier 1 Certifying Ph   | ysician: To the be                        | est of mv kno       | owledge, deat                    | h occurre   | d at the tim                 | ne, date ar     | nd place. | and due to  | the cau               | se(s) and m | nanner as s            | tated.   |
|            | 24 h   | Medical          | (Check only 2 Medical Examone)   | niner: On the basi<br>and manne           | s of examina        | ation and/or in                  | vestigati   | on, in my o                  | pinion, dea     | th occurr | ed at the   | time, date            | and place   | , and due to           | the cause(s)                                   |
|            | To the within 2 To the comple  | Me               | 29b. Signature and title of certifier                                      | 2/  | /                   |                                  | 2           | 9c. Licenso                  | number          |           |             | 29d                   | . Date sign | ed (Month,             | Dey, Year)                                     |
|            | P S F ŏ  |                  | //////   | 1,00                                      | -                   |                                  |             | D                            | 2409            | 3         |             | D                     | ecemb       | er 30                  | , 2005   |
|            | •  |                  | 1 vous our   | meso:                                     | 4 40 - 11 - 11      | - 00c) C                         | Delient     |                              |                 | -         |             |                       |             |                        | ,  |
|            | 13   |                  | 30. Name and address of person who Mark Parkhurst, M                       |   |                     | m 23a)(Type,<br>7 <b>i</b> s Ave |             | Suit                         | e 20            | 0 Ri      | iverd       | ale,                  | Mary        | land                   | 20737  |
|            | 1  |                  | · ·  | 32 B                                      | istrar's Signa      |                                  | 4           |                              |                 |           |             |                       | - 1         |                        |  |
|            | Sta<br>Registi   |                  | 31. Date filed (Month Perchan)   | 2005                                      | CE AREN             | B. A                             | park        | 1                            |                 |           |             |                       |             |                        |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death STANLEY FRANK ROGOWSKI **Physician** DÉCEMBER 29 2005 12:40 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIVERVIEW NURSING HOME **ESSEX** BALTIMORE Months Days Hours Min. 8. Date of Birth 0 8/7 5 3 3 5. Social Security Number .Sex f M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 72 MARYLAND 213307918 Director Usual Residence of Deceden the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10b County itam 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Examinar must be notified at MD BALTIMORE ROSEDALE 1 Yes 24 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8111 DUVALL AVE 21237 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Apped Forces? 1 Ayes 2 □ No If Yes, Give Year or Dates: KOREA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exertinal. 2006. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 XWidowed 4 ☐ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4or 5+) REEL HANDLER STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) FRANK ROGOWSKI AGNES KOKOSZKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICKI L. GURSKI / DAUGHTER 120 E. KINGSTON PK LN BALTO., MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place)
CEDAR HILL CEM Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXxurial 2 ☐ Cremation 3 ☐ Removal from State 12/31/05 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 1211 CHESACO AVENUE BALTO, MD 21237 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Wele Demontia **Physician** -5 months /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown this certificate has been signed by I al director, page 2 should be detach Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 a ramo 1 Yes 2 No 3 Probably 4 Honknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes : After this certifical funeral director, p or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred s after dec. 112 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours af To the Funaral D completely filled in 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASEEM. 70 9. BASTERN BLUD, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEC 3 0 2005 Registrar

|                   |   |                | For State Registrer  | State of Marylar  |  | artment of  |                                     |  | giene 005   | 42201  |
|-------------------|---|----------------|--|---|--|---|-------------------------------------|--|---|--|
|                   | Physici<br>/Medic   |                | 1. Decedent's Name (First, Middle, Las.  | Russell   |  |   |                                     | 2. Date of De<br>Month<br>Dec                    | Day 4 Year 200                                    |  |
| Lis               | Examin<br>Funeral   |                | Social Security Number     6. Se   | iland Medica  | last birthday)                             | 4b. City, Town But If Under 1 Ye Months Day           |                                     | 2  | th 9. Bit   | rthplace (State or Foreign                         |
|                   | Director  |                | 214-38-9029 Usual Residence of Decedent  10a. State 10b. County  | X   | Yrs.<br>Ty, Town or Lo                     |   |                                     | June 24  | , 1940 Peni                                       | nsylvania  |
|                   | e Maryla<br>le-f ahor   | ctor           | Maryland Harford   | _   | ppa  | Cation  |                                     |  |   | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No             |
|                   | with th   | Director       | 10e. Street and Number 667 Towne Center 1  | mirro   |  | 10f. Zip Cod  |                                     |  | 10g. Citizen of What C                            | ountry?  |
| 9036              | be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural, or iteme 23e or 28e-1 ahow avent, the Medical Exercion Liust I'm Indiffied at | d by Funeral   | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 12 Yes 2 □ No<br>If Yes, Give<br>Year or Dates:      |  | 21085 Was Decedent of fres, specify C                 | of Hispanic Orig<br>Juban, Mexican, | jin? (Specify Yes or No<br>, Puerto Rican, etc.) | - 14. Race - Am<br>Black, Whi                     | te, etc.   |
| 21215-0036        | within 72 h<br>ene.<br>then "nett   | Completed      | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)  |   | (Give                                      | dent's Usual Oci<br>kind of work do<br>DO NOT use ret | ne durina most                      | of working                                       | 16b. Kind of Business                             | /Industry  |
| d 21              | filed wit<br>Hygiene<br>ther the  | е Соп          | 17. Father's Name (First, Middle, Last)  | 2   | Vice                                       | Presid  |                                     | r's Name (First, Middle,                         | Transporta  | ation  |
| Maryland          | should be<br>ind Mental<br>marked o   | To Be          | Lewis Glenn Russel   |   |  |   |                                     | ced (nmn) S                                      | ŕ   |  |
| Mar               | s 1 and 2 should<br>f Health and Men<br>item 27 is marks<br>other treumatic   |                | 19a. Informant's Name/Relationship (T) Servet Russell/wit  | •   |  |   |                                     | rorRuralRouteNumbe                               | er, City or Town, State,  MD 21085                | Zip Code)  |
| Baltimore,        | permit. Pages 1 a<br>Department of Hea<br>Important: If itam<br>any injury or othe<br>once.   |                | 20a. Method of Disposition  ↑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,  | ! ,   | Place of Dispo<br>cemetery, crer<br>Nation | sition (Name of<br>natory or other p<br>ial Memo      | orial De                            | Date ec. 30,2005                                 | 20c. Location - City or Laurel, Ma                | uryland  |
| Balt              | permit. Depart Import any inj   |                | 21. Signature of Funeral Service Licens  | ee<br>~   | 13   | 2. Name and Ade                                       | dress of Facility<br>sbury F        | McComas Funda., Abingdo                          | neral Home,<br>on, MD 2100                        | P.A.   |
|                   | Dhysisian   |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only o<br>Immediate Cause (Final   | ications that caused the deat<br>ne cause on each line.   |  | 1   | . 1                                 |  | rrest,  | Approximate<br>Interval Between<br>Onset and Death |
| E.                | Physician<br>/Medical<br>Examiner   | Î              | disease or condition resulting in death)   | Due to (or as a conseq  | Uence of):                                 | ial ce  | 11 Car                              | cinoma   |   |  |
| ),                | icate be executed physician and the burial-transit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence.  Due to (or as a consequence)  |  |   |                                     |  |   |  |
| 8760,             | icate be<br>physicia<br>s the bur   | dicai          | (  | d   |  |   |                                     |  |   |  |
| P.O. Box 6        | ath certif<br>ttending<br>or use as   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d<br>9 ☐ Unknown | ideath 3                                   | Ectopic pregna<br>Other (specify)                     |                                     |  | 23d. Date of de<br>Month                          | livery<br>Day Year                                 |
|                   | uires that the de<br>i signed by the a<br>Id be deteched f  | by             | Part II. Other significant conditions co   | ntributing to death but not res   | ulting in the u                            | nderlying cause                                       | given in Part I.                    |  | obacco use contribute to                          | o the cause of death?                              |
| Il Records,       | The law require<br>ate has been sin<br>page 2 should b  | Completed      |  |   |  |   |                                     | 24a. Was<br>autop<br>perfo<br>1 Yes              |   | utopsy findings available completion of cause of   |
| Vita              | /sician: Th<br>s certificate<br>director, pag   | To Be          | 25. Was case referred to medical examiner? 1 Tyes 2 No   | Hospital: Inpatient 2   | ER/Outpatien                               | it 3 DOA  | Other                               | of Death  Check only o                           | ne <br>dence 6 □Other (Spe                        | na fici  |
| Division of Vital | To the Hospitel or Attending Physicien: Ty within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pa  | ation: T       | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury                     | 28c. ln   | njury at<br>Vork?                   | 28d. Describe h                                  | now injury occurred                               | city   |
| Divis             | el or Atters after des l'Director din by the  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - At he building, etc. (Specification)   | ome, farm, str                             | eet, factory, office                                  | C8                                  | 28f. Location (S<br>City or Ton                  | Street and Number or Ri<br>vn, State)             | ural Route Number,                                 |
|                   | ha Hospit<br>n 24 hour<br>he Funere<br>cletely fille  | edical (       | 29a. Certifier (Check only one) 2 Medical Exami  | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.                   | wledge, death<br>tion and/or in            | occurred at the<br>vestigation, in m                  | time, date and<br>y opinion, death  | d place, and due to the chocurred at the time,   | cause(s) and manner as<br>date and place, and due | s stated.<br>a to the cause(s)                     |
| 1                 | To t<br>To t<br>com   | M              | 29b. Signature and title of certifier  | 710 - M   | D  |   | ense number                         |  | 29d. Date signed (Mont                            |  |
| ,                 | 175,  |                | 30. Name and Jiddre of erso who c  | ompleted cause of death (Item   | n 23a) (Type,                              | Print)  |                                     |  | 1)ec 24   |  |
|                   | Sta   | te             | 31. Date filed (Nonth, Day, Year)  | 32. Registrar's Signa   | NTN G                                      | reene!  | street                              | baltmore   | MD 21   | 201  |
|                   | Registr   | -001           | DEC 3 0 20   | 005   | de la                                      | and s   |                                     |  |   |  |

|                     |   |               | For<br>State<br>Registrar  | State of Maryland / Dep   | artment of Health a   |  | 2005 42202   |
|---------------------|---|---------------|--|---|---|--|--|
|                     |   | 2             | Decedent's Name (First, Middle, Last,  | )   |   | 2. Date of Death   | 3. Time of Death   |
| п                   | Physici<br>/Medic   |               | GERTRUDE   |   | RUBINSTEIN  | DECEMBER   | 25 2005 11:35 P M  |
|                     | Examin  |               | 4a. Facility Name (If not institution, give                                      | street and number)  | 4b. City, Town, or Location of  |  | 4c. County of Death  |
|                     |   | *             | NORTH OAKS HEALT   |   | PIKESVILLE  |  | BALTIMORE  |
| 185                 | Funeral<br>Director   |               | 2.0 20 0// 1   | 7. Age (In yrs. last birthday 91 Yrs.   | ) If Under 1 Year If Under 2<br>Months Days Hours                       | 8. Date of Birth 11/04/19                                  | 9. Birthplace (State or Foreign Country) NJ                          |
|                     | and   |               | Usual Residence of Decedent  10a. State 10b. County                              | 10c. City, Town or L  | ocation   |  | 10d. Inside City Limits  |
|                     | Maryl<br>f sho  | 0             | MD BALTIM  | ORE BALTIMO   | NF.   |  | 1 ☐ Yes 2 ☑ No   |
|                     | 28a   | Director      | 10e. Street and Number   | ONE DIRECTION   | 10f. Zip Code   | 10   | g. Citizen of What Country?  |
|                     | 3a or   |               | 725 MT. WILSON   | 1 ANF   | 21208   |  | U.S.A.   |
|                     | death<br>ms 2   | Funerai       |  | 12. Was Decedent Ever in U.S. 13.   | Was Decedent of Hispanic Orig   | in? (Specify Yes or No-                                    | 14. Race - American Indian,  |
| 21215-0036          | d within 72 hours afler death with the Maryland<br>Jiene.<br>r than "natural", or Items 23a or 28a-f show<br>the Medical Exempler must be mailfied at | by            | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                           | Armed Forces?  1  | If Yes, specify Cuban, Mexican,  1 ☐ Yes 2 ☐ No Specify:                | , Puerto Hican, etc.)                                      | Black, White, etc. Specify: WHITE                                    |
| 20                  | 72 ho   | Completed     | 15. Decedent's Edu<br>(Specify only highest grad                                 | (Giv  | edent's Usual Occupation<br>e kind of work done during most             | of working   | 6b. Kind of Business/Industry  |
| 21                  | within 7<br>ene.<br>than "r   | nple          | Elementary/Secondary (0-12)  | College (1-4or 5+)  | DO NOT use retired)   |  |  |
| 21                  | filed w<br>Hygier<br>other th   |               |  | 4 OWNE  |   |  | LOOR COVERING  |
| Maryland            | ad al   | To Be         | 17. Father's Name (First, Middle, Last) PHILIP                                   | GOLDFAR   |   | r's Name <i>(First, Middl</i> e, <i>M</i><br>RAH           | UNOBTAINABLE   |
| lan)                | 2 should<br>and Men<br>Is marke<br>sumatic  |               | 19a. Informant's Name/Relationship (Ty   | ype, Print) 19b. Mail   | ing Address (Street and Number  | r or Rural Route Number,                                   | City or Town, State, Zip Code)                                       |
|                     | 1 and<br>Health<br>em 27<br>thar tr   |               | LARRY RUBINSTEIN   |   | N. MARTEL AVE   |  | -  |
| ore                 | 000-  |               | 20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ F                       |   | ematory`or other place)   |  | Oc. Location - City or Town, State                                   |
| Ē                   | tant:   |               | 4 Donation 5 □ Other (Specify)   | CEDAR PAR   |   | -  | EMERSON, N.J.  |
| Baltimore,          | permit. Pag<br>Department<br>Important: I<br>any injury o<br>gnce.  |               | 21. Signature of Funeral Service Licens  | 7   | 22. Name and Address of Facility  | SOL LEVINS   | ON & BROS., INC.   |
|                     |   |               | 23a. Part1. Enter the disease, or compl<br>shock, or heart lailure. List only or | lications that ceused the death. Do not en<br>ne cause on each line.  | IBYHA Moore Er Ayyd' Er Ryya g  | dillile oktobilatory arre                                  | Interval Between   |
|                     | Physician   |               | Immediate Cause (Final disease or condition                                      | Premoria  |   |  | Onset and Death  2 weeks   |
|                     | /Medical<br>Examiner  |               | resulting in death)  | Due to (or as a consequence of):  |   |  |  |
| ç                   | LAGITATION  | _             |  | b. Due to (or as a consequence of):   |   |  |  |
|                     | ed<br>isit  | Examine       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury    | Due to (or as a consequence of):  |   |  |  |
|                     | and<br>and<br>II-trar   | хап           | that initiated events resulting in death) Last                                   | c   |   |  |  |
| 8760,               | cate be executed<br>physician and<br>the burial-transit   | <u>a</u>      |  |   |   |  |  |
| 687                 | ficate<br>phys<br>s the   | edical        |  | d   |   |  |  |
| Вох                 | death certificate be executed<br>e attending physician and<br>id for use as the burial-transit  | Physician/Me  | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of pregnancy   | -1.5  |  | 23d. Date of delivery  |
|                     | death<br>e atte   | icia          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 4 Pregnant at time of death 5   | □Ectopic pregnancy<br>□ Other (s <i>pecify</i> )                        |  | Month Day Year   |
| P.O.                | t the<br>by th<br>ache  | hys           | 9 Unknown  | 9□ Unknown  |   |  |  |
| of Vital Records, F | Se Ge   | Ď             | Part II. Other significant conditions con  | ntributing to death but not resulting in the  | underlying cause given in Part I.                                       | 23e. Did toba<br>1 ☐ Yes                                   | acco use contribute to the cause ol death?                           |
| 00                  | > 10 0  | ompleted      |  |   |   | 24a. Was an  | 24b. Were autopsy lindings available                                 |
| Re                  | 0 5 0   | E             |  |   |   | autopsy  | prior to completion of cause of death?                               |
| ā                   | ician: Th<br>certificate<br>rector, pag   | C             | 25. Was case relerred to medical   |   | 26. Place   | of Death (Check only one                                   |  |
| >                   | S & S   | To B          | examiner? 1 Yes 2 No   | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie   | Othor   | sing Home 5 Residen  |  |
|                     |   |               | 27. Manne ol Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year) 28b. Time<br>Injury  |   | 28d. Describe how  |  |
| 9                   | Attanding r death. ector: After by the fune   | atic          | 2 Accident investigation   |   | M 1 Yes 2 N   | ło   |  |
| Division            | al or Attand<br>after death<br>Director:<br>d in by the   | ertification: | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home, larm, s building, etc. (Specify)  | treet, lactory, office  | 28l. Location (Stre<br>City or Town,                       | et and Number or Rural Route Number,<br>State)                       |
|                     | To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the  | edical C      | 29a. Certifier 1 Certifying Physical Composition 1 Certifying Physical Exami     | sician: To the best of my knowledge, dea<br>iner: On the basis of examination and/or in<br>and manner stated. | th occurred at the time, date and<br>nvestigation, in my opinion, death | I place, and due to the cau<br>h occurred at the time, dat | ise(s) and manner as stated.<br>e and place, and due to the cause(s) |
|                     | To the within 2. To the complet   | Me            | 29b. Signature and title of certifier  |   | 29c. License number   | 296  | d. Date signed (Month, Day, Year)                                    |
| )                   | 1   |               | > > / hum  | MO  | 03867   | 5  | 12/26/05   |
|                     | 0   |               | 30. Name and address of person who co  | ompleted cause of death (Item 23a) (Type  | , Print)  |  | ' 1  |
| _                   |   |               | JOAL MESHUL  | 1 1 1   | L PL SVITE  | 605 BAL  | 12/26/05<br>Amore M 2/202  |
| **                  | Sta<br>Registr  | -             | 31. Date liled (Month, Day, Year)<br>DEC 3 0 201                                 | 32 Registrar's Signature  | W.  |  |  |

|  |                      | For<br>State<br>Registrar   | State of   | of Marylar   |   | artmer<br><i>tificat</i>         |                          |                                  |                         | /lental Hy                            | giene<br>Reg.No.         | 05                                  | 42203  |
|--|----------------------|---|--|--|---|----------------------------------|--------------------------|----------------------------------|-------------------------|---------------------------------------|--------------------------|-------------------------------------|--|
| Physicia<br>/Medic   |                      | 1. Decedent's Name (First, Midd<br>Lillian Elizabe  | . ,  | ng   |   |                                  |                          |                                  |                         | 2. Date of De Month                   | Day 26                   | Year                                | 3. Time of Death  19:47 M  |
| Examin   | -0.00                | 4a. Facility Name (If not institution St. Agnes Hospi   | -  | ımber)   |   | Balt                             | imor                     | ce                               | n of Death              |                                       | N/A                      | unty of Dea                         | ath  |
| Funeral<br>Director  |                      | 5. Social Security Number 214-03-1077   | 6. Sex<br>1 ☐ M 2 🖾 F                            | 7. Age (In yrs.<br>90  | last birthday)<br>Yrs.                      | If Unde<br>Months                | Days                     | Hours                            | er 24 Hrs.<br>Min.      | 8. Date of Bi<br>(Month, D.<br>Nov. 9 | nth<br>ay, Year)<br>1915 | 9. Bi                               | rthplace (State or Foreign<br>Country)<br>'yland                 |
| f ehow   | tor                  | Usual Residence of Decedent           10a. State         10b. County           MD         Baltin                                |  | 10c. Ci  | ty, Town or Lo                              |                                  |                          |                                  |                         |                                       |                          |                                     | 10d. Inside City Limits  |
| 3a or 28a<br>at be notif   | al Direc             | 10e. Street and Number 3320 Benson Ave  | 2.   |  | Darti                                       |                                  | Code                     |                                  |                         |                                       | 10g. Citizer             |                                     | Country?   |
| natural, or iteme 23a or 28a-f ehow<br>idical Examiner must be notified at | by Funeral Director  | 11. Marital Status  1 Never Married 2 Mar  3XXWidowed 4 Divorce   | ned 1 ☐ Yes                                      | 2√No<br>ive  |   | Was Dece<br>f Yes, spe<br>1  Yes | cify Cuba                | lispanic (<br>an, Mexic<br>Speci | can, Puerto             | pecify Yes or N<br>Rican, etc.)       |                          | Race - Am<br>Black, Wh<br>ecify: Wh |  |
| other traumatic event, the Medical   | Completed            | 15. Decede<br>(Specify only higher<br>Elementary/Secondary (0-12)   | nt's Education<br>est grade completed<br>College | )<br>(1-4or 5+)  | 16a. Deced<br>(Give<br>life. I<br>Secre     | kind of wo<br>DO NOT u           | rk done                  | durina m                         | ost of worl             | king                                  | 16b. Kind                | of Busines:                         | ,  |
|  | To Be C              | 17. Father's Name (First, Middle John F. Kunkel   | •  |  |   |                                  |                          |                                  |                         | . Geist                               |                          | mame)                               |  |
| ner trauma   |                      | 19a. Informant's Name/Relation Carol L. Rubel:  | Danah  |  | 932   | Grove                            | Hi1                      |                                  | l. Ar                   | ral Route Numb<br>butus M             | D 2122                   | .7                                  |  |
| eny injury or oth<br>QDCB.   |                      | 20a. Method of Disposition  1  Burial 2  Coremation 4  Donation 5 Other (   | Specify)   |  | Place of Dispo<br>cemetery, crer<br>View C: | natory or c<br>remat             | other place<br>ory       |                                  | 12-3                    | Date 1-2005                           | Balti                    |                                     | r Town, State<br>MD  |
| SUCE   |                      | 21. Signature of Euneral Service  | The  | -  | At  | 719 F                            | e Fu                     | nera<br>onds                     | 1 Ho                    | me of L                               | ansdow                   |                                     |  |
| cian<br>dical  |                      | 23a. Part 1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Finaf disease or condition resulting in death) | t only one cause on                              | each line.   |   |                                  | -                        | _                                |                         |                                       | arrest,                  |                                     | Approximate Interval Between Onset and Death Onlday              |
| I for use as the burial-transit  | dical Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    | Due to   | epsis<br>or as a consec<br>emen<br>of or as a consec           | tia   |                                  |                          |                                  |                         |                                       |                          |                                     | 2 months   |
|  | hysician/Me          | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown   | 1 ☐ Live   | utcome of pregn<br>birth 2  Feta<br>gnant at time of c<br>nown | al death 3 🗌                                | Ectopic p<br>Other (s            |                          | ′ /                              | V/A                     |                                       | 230                      | I. Date of do<br>Month              | elivery<br>Day Year  |
| be det   | by P                 | Part II. Other significant condit   | ions contributing to                             | death but not res  | sulting in the u                            | nderlying                        | cause giv                | en in Pa                         | л І.                    |                                       | tobacco use<br>Yes 2     |                                     | to the cause of death?  Probably 4 Unknown                       |
| page 4 age   | Completed            |   |  |  |   |                                  |                          |                                  |                         | 24a. Wa<br>auto<br>peri<br>1 🗆 Yes    |                          | !4b. Were a prior to death?         | autopsy findings available<br>completion of cause of<br>s 200 No |
| the funera   | Certification: To Be | 3 ☐ Sutcide 6 ☐ Could   | Hospital: 128a. Oto (Mo                          | 1  | 28b. Time o<br>Injury                       | f<br>) м                         | 28c. Injur<br>Woi<br>1 🗍 | ner: 4 🗆                         | Nursing H               |                                       | how injury o             | ccurred                             | ecify)<br>Rural Route Number,                                    |
| completely filled in by  | edical Ce            | 29a. Certifier 1 Certify (Check only one)   | ing Physicien: To the                            | basis of examina   | owledge, deat<br>ation and/or in            | h occurred                       | at the tie               | me, date                         | and place<br>death occu | , and due to the                      | cause(s) an              | d manner a                          | as stated.<br>ue to the cause(s)                                 |
| ejdwoo   | Med                  | 29b. Signature and title of certifi   |  | nner stated.   |   | 29                               | lc. Licens               |                                  | ao7                     | 0                                     |                          | igned (Mor                          | nth, Day, Year)  |
| 3  |                      | 30. Name and address of perso   | who completed can                                | use of death (fte  | m 23a) (Туре,                               | Print)                           | Ave                      | ·, B                             | altim                   | ore ,                                 |                          |                                     |  |
| - Sta<br>Registr   | rar                  | 31. Date filed (Month, Day, Yea   | 4  | Registrar's Sign   | ature                                       | sisc                             | B .                      |                                  |                         |                                       |                          |                                     |  |

|          |   |                  | For State Registrar   | State of                           | Marylar                    | •                      | rtment of  |                         |                   |                                 | iene        | 05 4               | 12204  |
|----------|---|------------------|---|------------------------------------|----------------------------|------------------------|--|-------------------------|-------------------|---------------------------------|-------------|--------------------|--|
|          |   |                  | Decedent's Name (First, Middle, Last  | )                                  |                            |                        |  |                         | 2                 | . Date of Deat                  | h           |                    | 3. Time of Death                             |
|          | Physicia  |                  | WILLIAM   | E. STA                             | RR                         |                        |  |                         | 1                 | Month<br>Decembe                | er 25       | , 2005             | 10:10 a <sup>M</sup>                         |
|          | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give   | street and numb                    | er)                        |                        | 4b. City, Town,  | or Location             | of Death          |                                 | 4c. Cc      | ounty of Death     |  |
|          |   |                  | Mariner Health Car  | re of La                           | urel                       |                        | Laure  | 1                       |                   |                                 | Pri         | nce Geo            | rge's  |
|          | Funeral   |                  | 5. Social Security Number 6. Se   |                                    |                            | . last birthday)       | If Under 1 Yea<br>Months Days                            |                         | 24 Hrs. 8<br>Min. | . Date of Birth<br>(Month, Day, | Year)       | 9. Birthpl<br>Coun | lace (State or Foreign try)                  |
|          | Director  |                  |   | M 2 F                              | 60                         | Yrs.                   |  |                         | i                 | Apr. 26                         | , 19        | 45 PA              |  |
|          | and<br>*  |                  | Usual Residence of Decedent  10a. State 10b. County   |                                    | 10c. Ci                    | ity, Town or Lo        | cation   |                         |                   |                                 |             | 11                 | 0d. Inside City Limits                       |
|          | /anyl   | ō                | MD Howard   |                                    |                            | aurel                  |  |                         |                   |                                 |             |                    | 1 ☐ Yes 2 ☐ No                               |
|          | 28a-  | rect             | 10e. Street and Number  |                                    | 330                        | dulci                  | 10f. Zip Code  |                         |                   | 10                              | 0g. Citizer | n of What Coun     |  |
|          | 3a or   | □                | 8209 Cool Creek   |                                    |                            |                        | 20   | 723                     |                   |                                 | U.S.        | Α.                 |  |
|          | death with the Maryland<br>ms 23a or 28a-f show<br>r rust be nutified at  | Funeral Director | 11. Marital Status  | 12. Was Decede                     |                            | J.S. 13. V             | Vas Decedent of<br>Yes, specify Cu                       | Hispanic Ori            | igin? (Specif     | fy Yes or No-                   | 14.         | Race - Americ      |  |
| 0        | after<br>or Ita   |                  | 1 XX Never Married 2 ☐ Married  | Armed Force 1 XIXes 2 If Yes, Give | □No ±                      | 963                    | Tes, speciny Cu  |                         |                   | can, etc.)                      |             | Black, White,      |  |
| 2000     | ours<br>iral',  | d by             | 3 ☐ Widowed 4 ☐ Divorced  | Year or Date                       | s: -1                      | 968                    |  | o specily.              |                   |                                 | 34          | pecity: Wh         | ite  |
| ก็       | 72 h<br>"natu   | ompleted         | 15. Decedent's Edu<br>(Specify only highest grad  |                                    |                            | 16a. Deced<br>(Give    | ent's Usual Occi<br>kind of work don<br>OO NOT use retir | upation<br>e during mos | st of working     |                                 | 16b. Kind   | of Business/Inc    | dustry                                       |
| 7        | within  | ם                | Elementary/Secondary (0-12) Grade 12  | College (1-4                       | or 5+)                     |                        | sabled   | rea)                    |                   |                                 | TT C        | \$7.5.±            |  |
| 7        | iled v<br>Hygie<br>ther t   | ပ                | 17. Father's Name (First, Middle, Last)   |                                    |                            | DI                     | sabred   | 18 Mothe                | er's Name //      | First, Middle, N                |             | Vetera             | n  |
| yland    | ntal land of seva   | Be               | Francis James Star  | ~ 1~                               |                            |                        |  |                         | ·                 | Beregi                          | aldon da    | amo,               |  |
| 2        | 12 should be and Mental Is marked or raumatic eve   | 2                | 19a. Informant's Name/Relationship (7)  |                                    |                            | 19b. Mailin            | g Address (Stree   |                         |                   |                                 | City or To  | own. State. Zip    | Code)  |
| <u> </u> | d 2 s<br>lith ar<br>27 ls<br>trau   |                  | Donna Starr-Ghadir  |                                    | ster                       |                        | Cool C   |                         |                   | l, Mary                         |             |                    | ,  |
| ā,       | Hea<br>Hea<br>tem   | d 3              | 20a. Method of Disposition  |                                    | 20b.                       | Place of Dispos        | sition (Name of  | Ī                       | Dat               | 19-00                           |             | tion - City or To  | wn, State                                    |
| OE II    | ages<br>ant of<br>at: If i  |                  | 1 ☐ Burial 2 ☐ Cremation 3 🛱  |                                    | are I                      |                        | natory`or other pi<br>t Versa:                           |                         | 12/30/            | /05                             | McKe        | esport,            | PA   |
|          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  The mortant: If the 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic event, the Madical Examinat mast be notified a page. |                  | 21. Signature of Funeral Service Licens   |                                    |                            |                        | Name and Add   |                         |                   |                                 |             | ospor c,           | 211  |
| ä        | permi<br>Depa<br>Impo<br>any ii   |                  | 1 405-CA  |                                    | M0077                      | ០ រី                   | 13 Talbo   | ott Av                  | enue              | Laurel                          | , MD        | 20707              |  |
|          |   |                  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List on vio                              | lications that cau                 | sed the dea                | th. Do not ente        | er the mode of dy  | ing, such as            | cardiac or r      | espiratory arre                 | est,        |                    | Approximate<br>Interval Between              |
|          | Physician   |                  | Immediate Cause (Final disease or condition   |                                    |                            | noN1.                  | A  |                         |                   |                                 |             |                    | Onset and Death                              |
|          | /Medical  |                  | resulting in death)   |                                    | as a conse                 |                        |  |                         |                   |                                 |             | -                  |  |
|          | Examiner  |                  | Sequentially list conditions  | b. St                              | -ok+                       | e                      |  |                         |                   |                                 |             |                    |  |
| 7        | sit ad  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Unidenting Cause (Disease or injury | Due to (or                         | as a consec                | quence of):            |  |                         |                   |                                 |             |                    |  |
| V        | be executed<br>ician and<br>burial-transit  | хаш              | that initiated events resulting in death) Last  | c.<br>Due to (or                   | as a conse                 | uneuce of).            |  |                         |                   |                                 |             | -                  |  |
| Ç<br>Q   |   | cal E            |   |                                    |                            | ,                      |  |                         |                   |                                 |             |                    |  |
| 29       | law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the  | ) de             |   | d                                  |                            |                        |  |                         |                   |                                 |             |                    |  |
| ŏ        | leath certifical<br>attending phy<br>I for use as th  | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outco                 |                            |                        |  |                         |                   |                                 | 23d         | d. Date of delive  | ry   |
| ň        | death<br>a atte   | iciai            | in the past 12 months?  | 1□Live birt<br>4□Pregnar           | t at time of               |                        | Ectopic pregnan<br>  Other (specify)                     | cy                      |                   |                                 |             | Month              | Day Year                                     |
| j.       | t the cay the achec   | hys              | 9 □ Unknown   | 9∐ Unknow                          | 'n                         |                        |  |                         |                   |                                 |             |                    |  |
| ν,<br>T  | w requires that the de<br>been signed by the<br>should be detached  | by P             | Part II. Other significant conditions co  | ntributing to dea                  | th but not re              | sulting in the ur      | iderlying cause g  | iven in Part I          | l.                | 23e. Did tob                    | acco use    | contribute to th   | e cause of death?                            |
| coras    | en sig  |                  |   |                                    |                            |                        |  |                         |                   | 1 □ Ye                          | s 2 🗹       | No 3 ☐ Proba       | ably 4 □Unknown                              |
| ပ္       | aw re   | ompleted         |   |                                    |                            |                        |  |                         |                   | 24a. Was ar<br>autopsy          |             | 24b. Were autop    | osy findings available inpletion of cause of |
| r        | The<br>ate h  | Com              |   |                                    |                            |                        |  |                         |                   | perform                         | No No       | death?             | 2. No  |
| VITa     | sician: The law<br>certificate has k<br>irector, page 2 s   | Be               | 25. Was case referred to medical examiner?  |                                    |                            |                        |  |                         | of Death (        | Check only one                  | 9)          |                    |  |
| _        | h<br>sic<br>d   | ပို              | 1 Tes 2 No  | Hospital: 1 ☐ Inc                  | _                          | ER/Outpatien           | 3 DOA  | -                       |                   |                                 |             | Other (Specify     | )  |
| _        | oding Physician:<br>th.<br>: After this certifics<br>funeral director, f  | ů.               | 27. Mann of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of (Month,               | Injury<br><i>Day Year)</i> | 28b. Time of<br>Injury | 28c. Inj<br>W  |                         |                   | d. Describe ho                  | w injury o  | ccurred            |  |
| S<br>S   | tendi<br>leath.<br>tor: A   | catl             | 2 Accident investigation 3 Suicide 6 Could not be   |                                    |                            |                        |  | ⊒Yes 2□                 |                   | Langting /Ct                    | ant and A   | lumbas as Ours     | l Cause Alimbas                              |
| DIVISION | To the Hospital or Attending Pl<br>within 24 hours after death.<br>To the Funeral Director: After the<br>completely filled in by the funera   | Certification;   | 4 Homicide determined   | building                           | , etc. <i>(Speci</i>       | ify)                   | eet, factory, office                                     | 9                       | 201               | City or Town                    |             | rumber or Hurai    | Route Number,                                |
| _        | pital   |                  | 29a. Certifier 1 Certifying Phy   | sician: To the h                   | est of my kn               | owledge death          | occurred at the  | time date an            | nd place, and     | d due to the ca                 | use(s) an   | d manner as st     | ated   |
|          | 24 hg<br>24 hg<br>Fun<br>etely  | edical           | (Check only 2 Medical Exam  |                                    | is of examin               |                        |  |                         |                   |                                 |             |                    |  |
|          | vithin<br>o the   | Me               | 29b. Signature and tiple of certifier   | 1 /                                | 1:                         |                        |  | nse number              |                   |                                 |             | igned (Month L     |  |
|          | ,- ,- 0   |                  | 1 Lann  |                                    |                            | · C                    | 005  | 323                     | 5                 |                                 | 121         | 27/0               | 5  |
|          | 641   |                  | 30. Name and address of person who c  | ompleted cause                     | of death (Ite              | m 23a) (Type,          | Print  | 11                      | P .               |                                 | ,           | •                  | / /  |
|          | 7   |                  | Varryl  | 1/11/                              |                            | 363.                   | 3 3  | alti                    | mor               | e F                             | tvei        | rue,               | Saurel                                       |
|          | Sta   |                  | 31. Date filed (Month, Day, Year)   | 100                                | istrar's Sign              | ature                  |  |                         |                   | 140-1                           |             |                    |  |
|          | Registr   | rar              | DEC 3 0 200   | 5 430                              | how he                     | 1 600                  | de   |                         |                   |                                 |             |                    |  |

|            |   |                  | 1 - For<br>State<br>Registrar  | State of Maryland /  | Department of Health ar<br>Certificate of Death                                       |   | ne 005 42205   |
|------------|---|------------------|--|--|---|---|--|
| 1          |   |                  | Decedent's Name (First, Middle, Las  | 7 1  |   | 2. Date of Death  | 3. Time of Death   |
|            | Physici<br>/Medic   |                  | SARAH  | SMI/H  |   | December  | 29, 2005 1:35AM  |
| 1-         | Examir  |                  | 4a. Facility Name (If not institution, give  |  | 4b. City, Town, or Location of I  | 1000  | 4c. County of Death  |
|            | Funeral<br>Director   |                  | 212-87-0171  | 7. Age (In yrs. last b   |   | Hrs. 8. Date of Birth (Month, Day, Y                    | 9. Birthplace (State or Foreign<br>Coughty) Carelina             |
|            | and   |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Tov   | wn or Location  |   | 10d. Inside City Limits  |
|            | Marylan<br>f show   | ō                | Ma als   | Balt   | more  |   | 11 Yes 2 No  |
|            | r 28a   | irec             | 10e. Street and Number   | 0411   | 10f. Zip Code   | 10g   | . Citizen of What Country?                                       |
|            | th witi   | alD              | 1609 Appleton  | St.  | 21217   |   | 4S.A.  |
|            | 72 hours after death with the Maryland<br>naturel', or Items 23a or 28s-1 show<br>dical Exacultational by notified at | Funeral Director | 11. Marital Status   | 12. Was Decedent Ever in U.S.<br>Armed Forces?   | 13. Was Decedent of Hispanic Origin<br>If Yes, specify Cuban, Mexican, F              | n? (Specify Yes or No-<br>Puerto Rican, etc.)           | 14. Race - American Indian,<br>Black, White, etc.                |
| 36         | s afte  | by Fi            | 1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 MANo<br>If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 ♣ No Specify:   |   | Specify: Black   |
| 21215-0036 | "naturel",  |                  | 15. Decedent's Edi   | ucation 16a  | a. Decedent's Usual Occupation  | 16  | b. Kind of Business/Industry                                     |
| 215        | within 72<br>ene.<br>then "n  | piet             | (Specify only highest grad<br>Elementary/Secondary (0-12)  | de completed)  College (1-4or 5+)  | (Give kind of work done during most of<br>life, DO NOT use retired)                   | f working   | 1  |
|            | be filed within 72 ho<br>tal Hygiene.<br>Id other then "natu<br>event, ine Modical                                    | Completed        | 12   | Soliogo (1 tol 51)   | Housekeeper   |   | Domestic   |
| land       | be filed<br>ital Hygi<br>of other<br>event, I   | Be               | 17. Father's Name (First, Middle, Last)  | / /  | 18. Mother's  | Name (First, Middle, Ma                                 | iden Sumame)   |
| Z          | should be<br>ind Mental<br>s marked o<br>umatic eve   | 2                | 19a. formant's Name/Relationship (7  | olard  | Kat   | il Jaco,  | 6  |
| Maryl      | s 1 and 2 should<br>F Health and Mer<br>Item 27 is marke<br>other traumatic   |                  | Kiti Cnow from   | 1  | b. Mailing Address (Street and Number of  | St Toll   | 111  |
| ē,         | f Heal<br>f Heal<br>tem   |                  | 20a. Method of Disposition   |  | of Disposition (Name of ery, crematory or other place)                                | Date 20   | c. Location - City or Town, State                                |
| altimore   | Pages<br>ment of<br>ant: If II  |                  | 1 Surial 2 □ Cremation 3 □ I<br>4 □ Donation 5 □ Other (Specify  | Tellioval Irolli State   |   | n 5 2006 /  | Balto. led.  |
| alti       | in out  |                  | 21. Signature of Funeral Service Licens  | 2  | 22. Name and Address of Facility  | a Fan ral   | Service P.A.   |
| <u> </u>   | Dep<br>Imp  |                  | Callor C.  | Douglan  | not enter the mode of dying, such as cal  | or Balto M  | 0.2/2//  |
|            | Priysician<br>/Medical<br>Examiner  | Examiner         | snock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a  | nonia<br>SIVE CARDIOU   | ASCULAR   | Interval Between<br>Onset and Death                              |
| 8760,      | cate be executed oblysician and the burial-transit  |                  | that initiated events resulting in death) Last   | Due to (or as a consequence  |   |   |  |
| 687        | ficate<br>phys<br>s the   | edical           |  | d  |   |   |  |
| .O. Box    | at the death certifics<br>by the attending pt<br>tached for use as t  | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown                        | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown | n 3 □Ectopic pregnancy<br>5 □ Other (specify)   |   | 23d. Date of delivery<br>Month Day Year                          |
| Δ.         | s that  | by Ph            | Part II. Other significant conditions co   | ntnbuting to death but not resulting   | in the underlying cause given in Part I.  | 23e. Did tobac  | co use contribute to the cause of death?                         |
| Records,   | The law requires that<br>ite has been signed b<br>page 2 should be deta   | ed b             |  |  |   | 1 🗆 Yes   | 2 No 3 Probably 4 ∃Unknown                                       |
| 900        | aw re   | Completed        |  |  |   | 24a. Was an   | 24b. Were autopsy findings available                             |
| Œ.         |   | Com              |  |  |   | — autopsy performed 1 ☐ Yes 2 🛣                         |  |
| Vital      | Physician:<br>this certifica<br>ral director, p   | Be (             | 25. Was case referred to medical examiner?   |  |   | Death (Check only one)                                  |  |
| of         | this<br>al dir  | 2                | 1 Yes 2 No 27. Manner of Beath   | Hospital: 1 Heatient 2 ER/O  |   | ng Home 5 Residenc                                      |  |
|            |   | tion             | 1. Natural 5 Pending   |  | Time of lnjury at Work?  M 1 Yes 2 No   | 28d. Describe how                                       | injury occurred  |
| Division   | De S  | flca             | 3 Suicide 6 Could not be   | 28e. Place of Injury - At home, fa   |   | 28f. Location (Stree                                    | t and Number or Rural Route Number.                              |
| ā          | al or after   | Certification    | 4  Homicide determined   | building, etc. (Specify)   |   | City or Town, S   |  |
|            | To the Hospital or Atto<br>within 24 hours after de<br>To the Funeral Directo<br>completely filled in by the          | edical (         | 29a Certifier 1 entiryin Phy<br>(Check only one) 2 Medical Exam  | sician: To the baut of my knowledger: On the basis of examination are and manner stated.           | a death occurred at the time, data and pand/or investigation, in my opinion, death of | lace, and due to the eaus<br>occurred at the time, date | u(s) and manner as stated.<br>and place, and due to the cause(s) |
|            | To the P  | Me               | 29b. Signature and title of certifier  | 0 0 -  | 29c. License number   |   | Date signed (Month, Day, Year)                                   |
|            | 1   |                  | Kohnto   | K. cruga   | D003035   | 2   | ecember 29, 2005   |
|            | Ó   |                  | 30. Name and address of person who co  | ompleted cause of death (It = 2 a)   | (Type, Print) BOX SE  | = COUPS   | Hospital   |
| 1          | Sta   | _                | 31. Date filed (Month, Day, Year)  | 32 Registrar's Signature   |   |   |  |
| 53         | Registr   | - 4              | DEC 3 0 200  | March M.   | And I   |   |  |
| DH         | MH 17 Rev 1/2   | 001              |  |  |   |   |  |

DHMH 17 Rev 1/2001

Registrar

0 2005

Registrar

State

31. Date filed (Month, Day, Year)

DEC 3 0

2005

Registrar's Signature

|                                |   |                               | For<br>State<br>Registrar   |                      | State o  | f Mai                  | rylan                |                                 | artmen<br>rtificat        |                          |                          |                     | lental H                       | ygier<br>Reg. 1     | ZUI                      | )5                            | 422                                       | 08            |
|--------------------------------|---|-------------------------------|---|----------------------|--|------------------------|----------------------|---------------------------------|---------------------------|--------------------------|--------------------------|---------------------|--------------------------------|---------------------|--------------------------|-------------------------------|---|---------------|
|                                | Physici<br>/Medic   |                               | 1. Decedent's Name (First, Mid<br>Andrew  | idie, Last)          |  |                        |                      | Simi                            |                           |                          |                          |                     | 2. Date of D<br>Month<br>Decem | ber                 |                          | Year<br>2005                  | 3. Time of                                |               |
| j.                             | Examir  | er                            | 4a. Facility Name (If not institut  |                      | 4.5  | 2 5                    | 5 . 0 . 16 0 . 1     |                                 |                           |                          |                          |                     | 1                              | •                   | tc. County               | y of Death                    |   |               |
|                                | Funeral   |                               | The Johns Ho 5. Social Security Number  |                      | XM 2□F   |                        |                      | last birthday)                  | If Under                  | 1 Year                   | If Under                 |                     | 8. Date of B                   | irth                |                          |                               | place (State o                            | or Foreign    |
|                                | Director  |                               | 150-06-3912   | )AC                  | <b>M</b> M 2□F                                 |                        | 6                    | Yrs.                            | Months                    | Days                     | Hours                    | Min.                | Novemb                         | er 2                | 24,19                    | 99 Cour                       | ŇJ  |               |
|                                | /land   |                               | Usual Residence of Decedent  10a. State 10b. Cour   | nty                  |  |                        | 10c. Cit             | y, Town or Lo                   | ocation                   |                          |                          |                     |                                |                     |                          | 1                             | IOd. Inside C                             | ity Limits    |
|                                | e Man   | ctor                          | NJ Camd   | en                   |  |                        | Che                  | rry Hi                          | 11                        |                          |                          |                     |                                |                     |                          |                               | 1 🗆 Yes                                   | 2 <b>X</b> No |
|                                | with th   | Dire                          | 10e. Street and Number  | A                    |  |                        |                      |                                 | 10f. Zip                  | Code<br>834              |                          |                     |                                | _                   | Citizen of               | What Cour                     | ntry?                                     |               |
|                                | ns 23   | erai                          | 113 E. Miami  | Aven                 | 12. Was Dece                                   | edent Ev               | er in U.             | .S. 13.                         |                           |                          | spanic Ori               | gin? (Spe           | ecify Yes or N<br>Rican, etc.) |                     |                          | ce - Americ                   | an Indian,                                | <del></del>   |
| 36                             | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or Itams 23e or 28e-f ahow any Injury or other traumatic avant, the Medical Examinar must be notified at once. | Completed by Funeral Director | 1 Never Married 2 M<br>3 Widowed 4 Divord   |                      | Armed Fo<br>1 Tyes<br>It Yes, Giv<br>Year or D | 2XXNo                  |                      | 1                               | lf Yes, spe<br>1 □ Yes    |                          | Specify:                 |                     | Rican, etc.)                   |                     | Specii                   | ick, White,<br>fy: <b>Whi</b> |   |               |
| 9                              | 2 hour  | ted t                         | 15. Deced   | ent's Edu            | cation   |                        |                      | 16a. Dece                       | dent's Usua               | al Occupa                | ition                    |                     |                                | 16b.                | Kind of B                | Business/In                   | dustry                                    |               |
| 215                            | thin 7.   | nple                          | (Specify only hig<br>Elementary/Secondary (0-12   | -                    | e completed)<br>College (                      | 1-4or 5+               | )                    |                                 | kind of wo<br>DO NOT u    | rk done d<br>se retired, | <i>uring</i> mosi        | t of worki          | ing                            |                     | _                        |                               | ,   |               |
| 12                             | iled wi<br>tygien<br>her th   | ပ္                            | 0<br>17. Father's Name (First, Midd   | (a. ( ast)           |  |                        |                      | infa                            | nt                        | 1                        | 19 Mothe                 | ore Name            | e (First, Middl                |                     | infan                    |                               |   |               |
| Baltimore, Maryland 21215-0036 | id be fiental h   | To Be                         | Christopher S   |                      | rs   |                        |                      |                                 |                           |                          |                          |                     | eline                          |                     |                          |                               |   |               |
| lary                           | 2 shou<br>and N<br>is mar   |                               | 19a. Informant's Name/Relation  |                      |  |                        |                      |                                 | -                         |                          |                          |                     | al Route Num                   |                     |                          |                               | Code)                                     |               |
| e,<br>S                        | of Heelth are Itam 27 is other trau   |                               | Jacqueline Sin  | mers                 | / Moth   | er                     | 20h P                |                                 |                           | ericanina in terretaria  |                          |                     | erry Hi                        | -                   |                          | )8834<br>- City or To         | Ctata                                     |               |
| nor                            | ages<br>int of h<br>t: if its   |                               | 1 Burial 2 Crematic   |                      |  | State                  | _                    | lace of Dispo<br>emetery, crei  | _                         |                          |                          |                     |                                |                     |                          |                               |   |               |
| altir                          | mit. P<br>pertme<br>portan<br>/ Injur   |                               | 21. Signature of Funeral Servi  |                      |  |                        | Ua.                  | lvary                           | 2. Name ar                |                          |                          |                     | 0,2005<br>oway F               |                     |                          |                               | , NO                                      |               |
| <u> </u>                       | 88 188  |                               | MIV   |                      |  | U                      | bill                 | 3 3                             | 15 E.                     | Мар                      | le Av                    |                     | lerchan                        |                     |                          |                               | 3109                                      |               |
|                                | Physician   |                               | 23a. Part1. Enter the lisease shock, or heart failure. L<br>Immediate Cause (Final disease or condition resulting in death) | or complist only or  | ications that one cause on e                   | each line              |                      |                                 | arct                      |                          | g, such as               | cardiac             | or respiratory                 | arrest,             |                          |                               | Approximat<br>Interval Bet<br>Onset and I | ween          |
| 1                              | /Medical<br>Examiner  |                               | resulting in dealtry  |                      | Acost  | (or as a               |                      | uence of): '                    | ะกละ                      | 5 1                      | euk                      | (em                 | 10                             |                     |                          |                               | 30 mon                                    | ths           |
|                                | be dissit   | liner                         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                 | ₹ '                  | Due to   | (or as a               |                      | uence of):                      |                           |                          |                          | 10,111              | М                              |                     |                          |                               |   |               |
| ó,                             | death certificate be executed<br>e ettending physicien and<br>of for use as the burial-transit  | I Examiner                    | that initiated events resulting in death) Last  | · ·                  | Due to   | (or as a               | conseq               | uence of):                      |                           |                          |                          |                     |                                |                     |                          |                               |   |               |
| 68760,                         | tificate b<br>ig physic<br>as the bi  | edical                        |   |                      | d  |                        |                      |                                 |                           |                          |                          |                     |                                |                     |                          | lete                          |   |               |
| Box (                          | eath certif<br>ettending<br>for use a   | an/Me                         | IF FEMALE:<br>23b. Was decedent pregnant  | 2                    | 3c. If yes, out                                |                        |                      |                                 | ∃Ectopic pr               | ennancy                  |                          |                     |                                |                     |                          | ate of delive                 | ,   |               |
| P.O. B                         | that the death cer<br>ed by the ettendin<br>detached for use  | Physician/Med                 | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                      | 4□Pregr<br>9□ Unkn                             | ant at ti              |                      |                                 | Other (sp                 |                          |                          |                     |                                |                     | Mo                       | onth                          | Day *                                     | Year          |
|                                | S 5 0   | ۵                             | Part II. Other significant cond   | itions co            | ntributing to d                                | eath but               | not res              | ulting in the u                 | nderlying o               | ause give                | n in Part I.             |                     | _                              |                     | use con                  |                               | ne cause of d                             |               |
| Records,                       | w require<br>been signature   | leted                         |   |                      |  |                        |                      |                                 |                           |                          |                          |                     | 24a. Wa                        |                     | -                        |                               | psy findings                              |               |
| - Re                           | The<br>ste h<br>page  | Completed                     |   |                      |  |                        | -                    |                                 |                           |                          |                          |                     | aut                            | opsy<br>formed?     |                          | prior to con<br>death?        | mpletion of c<br>2□ No                    | ause of       |
| Vita                           | Physician: The<br>this certificete he<br>ral director, page   | Be                            | 25. Was case referred to med examiner?  | -                    | lospital:                                      | 137                    |                      |                                 |                           | Othe                     | ·F                       |                     | Check only                     |                     |                          |                               |   |               |
| to                             | Phys<br>r this<br>ral di  | . To                          | 1 Yes 2 No 27. Manner of Death  | I                    | 28a. Date                                      | Inpatient<br>of Injury |                      | ER/Outpatier<br>28b. Time of    |                           | 8c. Injury<br>Work       | 4 🗆 140                  |                     | me 5 Res<br>28d. Describe      |                     |                          |                               | v)  |               |
| ion                            | 를 는 중 글   | atlor                         | Z L Accident  | stigation            | (Mon   | th, Day                | Year)                | Injury                          | м                         |                          | ?<br>/es 2 🗆 1           | No                  |                                |                     |                          |                               |   |               |
| Division of Vital              | il or Atta<br>efter de<br>I Diracto<br>d in by th   | Certification;                |   | ld not be<br>ermined | 28e. Place<br>buildi                           | of Injur               | y - At he<br>(Specif | ome, farm, str                  | reet, factory             | r, office                |                          |                     | 28f. Location<br>City or To    | (Street<br>own, Sta | and Numb<br>ite)         | ber or Rura                   | l Route Num                               | ber,          |
|                                | To the Hospital or Attandwithin 24 hours efter death To the Funeral Director:   | Medical C                     | 29a. Certifier Cartification (Check only one)   | ying Phy<br>al Exami | sician: To the<br>nar: On the b<br>and man     | asis of e              | xamina               | wledge, death<br>tion and/or in | h occurred<br>vestigation | at the tim               | e, date an<br>inion, dea | d place, ath occurr | and due to the                 | e cause<br>, date a | (s) and mand mand place, | anner as st                   | ated. the cause(s                         | ;)            |
|                                | To the within 2 To the complet  | W W                           | 29b. Signature and title of pert  | ifier                |  |                        |                      |                                 | 1                         | . License                |                          |                     |                                | 29d. [              | Date signe               | ed (Month,                    | Day, Year)                                |               |
|                                |   |                               | · lon   | $\sim$               | *  | 1                      |                      |                                 | -                         |                          | 6181                     |                     |                                | 12                  | 1-25                     | - 200                         | 15  |               |
|                                |   |                               | 30. Name and address of pers  | on who co            | full o   | of dea                 | ath (Iten            | 23a) (Type.                     | Print)<br>No If           | e 5                      | t . P                    | alti                | more.                          | . 1                 | ND                       | 212                           | 87  |               |
|                                | Sta<br>Regist   |                               | 31. Date filed (Month, Day, Ye BEC 3  | ar)<br>0 20          | 05 32.   | gistrar                | 's Signa             | ture                            | feed                      | ,                        |                          |                     | more                           |                     |                          |                               |   |               |

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 Year Month **Physician** 20-00 Edward Frank Skowronski DECEMBER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rel Air
If Under 1 Year
Months Day 512 North Hickory Avenue Harford Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
(Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Yrs. Director 203-20-0828 80 March 6,1925 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ns 23a or 28a-f show 1X Yes 2 No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 512 North Hickory Avenue or itsms 23a 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, It a Madical Examiner Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced W II White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) School Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be finand Mental H Be Skowronski Bertha Zelninski John Louis (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Elizabeth Marcin Skowronski-Wife 512 North Hickory Avenue, Bel Air, MD 21014 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 iment of h tant: If it 1X Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Depertment of Important: If any injury of once. 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Mem. Gardens 12/28/05 Bel Air, Maryland 21. Signature Funeral Service License 22. Name and Address of Facility McComas Funeral Home, P.A. 50 West Broadway Street, Bel Air, MD 21014 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INFARCTION 5 MINUTES **Physician** ACUTE MYOCARDIAL /Medical Due to (or as a consequence of): D. ATHERO SCLEROTIC HEART DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, PARKINSON S 1 Tyes 2 No 3 Probably 4 Unknown DISEASE Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? OBSTRUCTIVE PULMONARY DISEASE performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🖃 No of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one | Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division t Matural 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide ō within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 21207 DECEMBER 24TH 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MIDCREST COURT 21286 UELLA- CAMILLERI 17.0. BALTIMORE C. 31. Date filed (Month, Day, Year) DEC~3~032. gistrar's Signature State 2005 Registrar

Skowrenski,

Amend Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Carl Matthew Sullivan 14. 2005 :30P December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1734 A Fountain Rock Way Harford Edgewood If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**X**M 2□ F 33 Director 28, 1972 Maryland 219**-**88-9228 Usual Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examenal rust be multilled at 1 Yes 2 No Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21040 USA 1734 A Fountain Rock Way deeth Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 2 should be filed within 72 hours after un and Mental Hygiene. Is marked other than "natural, or iter 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Allen Sullivan Sr. Dorothy Ann Blevins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Depertment of Health and Important: If Item 27 Is n any injury or other traun once. 1734 A Fountain Rock Way, Edgewood, Maryland 21040 William Sullivan Sr./Father 20b. Place of Disposition (Name of cometery, crematory or other place)
Bel Air Memorial Gar Dec. 17,2005 Bel Air, Maryland 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup>
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Signature of Funeral Service Licensee Willes 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepons Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 3-4 weeks umonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed ue to (or as a conseque ce of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cete has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Done Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificete Aspiration 2 AN Hospital or Attending Physician: 25. Was case refe ed to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home STResidence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ NO After this funeral dir 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. Jar 2 Accident Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number /DZA 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Rose Kurtom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cherapeall inve

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

2005

Registrar's Signature ---

Bel

Air, Maryland 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiege 05 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** CAROL ANN SHOCKLEY DECEMBER ZT 2005 08=55M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HARFORD BUZ AIL UPPERCHESAPEAKE MEMICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 Alaska 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 530-50-3881 Director July 23,1953 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County s 23a or 28a-f show 1 ☐ Yes 3 ☐ No Maryland Harford Edgewood Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 607 Longwood Court 21040 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates: Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Maryland 21215-0036 Specify: White ğ 3 ☐ Widowed 4 X Divorced and Mental Hygierre,
is marked other than "natural",
----matic avant, the Modical Ex leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 is Department of Health ar Important; If itam 27 is any injury or othar trau once. Dr. E. C. Fulcher, Jr.- Pastor 426 Bernice Terrace, Aberdeen, Maryland 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Services Inc. 12/30/05 Towson, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enfer the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SCLERO DELMA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Examine resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 **X** No 1 Tes Division of Vita Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 2 Accident filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D21809 4-0 DECEMBER 27 2005 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 95 PLASITUR 40 21093 2336 YONG 32. Registrar's Signature TIMONIUM LOAD 31. Date filed (Month, Day, Year) State DEC 3 0 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene [ 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death DECEMBER Physician S0K0L 27, 2005 3:31P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Saint Joseph Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 03/12/1957 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🙀 F Yrs 48 MD 212-74-4887 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-fehow the Medical Examiner must be nutified at 1 ☐ Yes 2☐ No Director TOWSON MD BALTIMORE 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 U.S.A. 238 500 VIRGINIA AVENUE SUITE 1207 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Items Black, White, etc. a filed within 72 hours after Il Hygiene. other then "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE Specify: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) TRAVEL TRAVEL AGENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any lijury or other traumatic event 908.8. **TROSCH** DOROTHY LEVY **ERWIN** IVAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 CANTERBURY RD. APT. 406 BALTIMORE, MD 21218 DONALD POLASHUK 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/29/2005 REISTERSTOWN, MD BALTIMORE HEBREW 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. aks 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disbase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) CHRONIC RENAL **Physician** FAILURE /Medical Due to (or as a consequence of): Examiner PERIPHERAL VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine signed by the attending physicien and a be detached for use as the burial-transit be executed c DIABETES MELLITUS that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No certificate 1 Tyes 1 Yes 2 No spitel or Attending Physician: Ti hours after death. nerel Director: After this certificate y filled in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 X ER/Outpatient 1 Inpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 42219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IBIKUNLE KOYR M. D 7601 OSLER DRIVE IOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 3 2005 Registra

|            |  |                | 1 - For<br>State<br>Registrar  | State of M  | Maryland / Dep<br><i>Ce</i>                      | artment of H  |   |                                      | Reg. No. UU5                              | 42213   |
|------------|--|----------------|--|---|--|---|---|--------------------------------------|---|---|
|            | Physici  | an             | 1. Decedent's Name (First, Middle, L   |   |  |   |   | 2. Date of Di<br>Month               |   | 3. Time of Death  |
|            | /Medic   | al             | JEAN ST<br>4a. Facility Name (If not institution, g  | EVENS   |  | 4b. City, Town, or  | Leasting of Dog                                   | DECEM.                               | SGR 25 2<br>4c. County of E               | 005 11:25PM   |
|            | Examin   | er             |  | ,   | tospital.  |   | TIMOR   |                                      |   | Jean  |
|            | Funeral<br>Director  |                |  | Sex 7. A  | Age (In yrs. last birthday<br>80 Yrs.            |   | If Under 24 Hrs<br>Hours Min                      | S. 8. Date of Bi                     | rth 9                                     | Birthplace (State or Foreign<br>Country)<br>aryland                     |
|            | pur *  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town or L                             | ocation   |   |                                      |   | 10d. Inside City Limits   |
|            | Maryla<br>1 eho  | ō              | MD Baltimo   | re  | Catonsvi   |   |   |                                      |   | 1 ☐ Yes 2√2 No  |
|            | 28a-   | Director       | 10e. Street and Number   |   |  | 10f. Zip Code   |   |                                      | 10g. Citizen of Wha                       | t Country?  |
|            | h with   | al D           | 303 Maiden Choic   | e Lane Apt  | 125  | 21228   |   |                                      | United Sta                                | ates  |
| 21215-0036 | in 72 hours after death with the Maryland<br>"naturel", or Iteme 23a or 28a-1 ehow<br>addell Exaturer must be rivilled at  | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☎ Widowed 4 ☐ Divorced  | 12. Was Deceder Armed Forces 1 Yes 2 F If Yes, Give Year or Dates | No   | . Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2∑No | ispanic Origin? (<br>an, Mexican, Pue<br>Specify: | Specify Yes or N<br>rto Rican, etc.) | o- 14. Race - A<br>Black, V<br>Specify: V | American Indian,<br>White, etc.<br>Vhite                                |
| 5-0        | 72 ho  | eted           | 15. Decedent's (Specify only highest of  |   | (Giv   | edent's Usual Occup   | during most of wa                                 | orking                               | 16b. Kind of Busine                       | ess/Industry  |
| 2          | within then the Mer  | Completed      | Elementary/Secondary (0-12)  | College (1-4o   | r 5+) //ife.                                     | DO NOT use retired<br>Maker                                 | 3)  |                                      | Own Home                                  |   |
| 2          | be filed within 72 ho<br>tal Hygiene.<br>d other then "naturelevent, I've Medicel  |                | 17. Father's Name (First, Middle, Las  | st)   | Home   | Hakei   | 18. Mother's Na                                   | ame (First, Middle                   | e, Maiden Sumame)                         |   |
| and        |  | ) Be           | Raymond Bell   | /   |  |   | Sophie  | , ,                                  | ,,  |   |
| Maryland   | should be<br>and Menta<br>is marked<br>sumatic ev  | ဠ              | 19a. Informant's Name/Relationship   | (Type, Print)   | 19b. Mai   | ling Address (Street  |   |                                      | per, City or Town, Sta                    | te, Zip Code)   |
|            | od 2<br>lith a<br>27 is  |                | Edward W. Steven   | s/Son   | 1307   | Moleswort   | h Rd. P   | arkton,                              | MD 21120                                  |   |
| Baltimore, | Pages 1 and nent of Healt in them 2 into the contract of them 2 into or other into the contract in the contrac |                | 20a, Method of Disposition  1 Burial 20 Cremation 3  4 Donation 5 Other (Spec  |   |  | position (Name of<br>ematory or other place<br>Crematory    | (e)<br>7 12-                                      | Date<br>-27-2005                     | 20c. Location - City Baltimore            |   |
| Balti      | permit. Pages<br>Department of<br>Important: if I<br>any injury or once.   |                | 21. Signature of Funeral Service (Icc  | J. Bay  | everto !   | Name and Addre<br>Ambrose Fu<br>1328 Sulph                  | ineral He<br>iur Sprii                            | ome, Inc                             | Arbutus MI                                | 21227   |
|            | Physician /Medical Examiner  pnual-Itansit   | Examiner       | 23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b   | as a consequence of):                            | n HE  | MATO A  | 1                                    | EXAMINER                                  | Approximate<br>Interval Between<br>Onset and Death                      |
| ,60        | be es  | ical E         |  |   |  | /   |   | /                                    |   |   |
| 68760,     | ficate I<br>physi<br>ts the t  | edic           |  | d   |  |   |   |                                      |   |   |
| P.O. Box   | Phyaician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 mogths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  |   | 2 Fetal death 3 at time of death 5               | ☐Ectopic pregnancy<br>☐ Other (specify)                     | /   |                                      | 23d. Date of<br>Month                     | delivery<br>Day Year  |
|            | es thet<br>igned b<br>be deta  | by Pt          | Part II. Other significant conditions  | contributing to death   | but not resulting in the                         | underlying cause giv  | en in Part I.                                     | 23e. Did                             | tobacco use contribu                      | te to the cause of death?   |
| ğ          | w require<br>been sig<br>should b  | edt            | LUNG   | CANC  | ER.  |   |   | 1 🗆                                  | Yes 2 □No 3.                              | Probably 4 Unknown  |
| Records,   | The law re<br>ete has be<br>page 2 sho   | Completed      | END S  | TAGE K  | IDNEY  | DISCAS  | G   | perf                                 | opsy prior deat                           | e autopsy findings available to completion of cause of h? Yes 2 \sum No |
| /ita       | ician: Th<br>certificete<br>rector, pag  | Be (           | 25. Was case referred to medical examiner?   |   |  |   |   | eath (Check only                     | опе)                                      |   |
| of Vital   | ding Phyaician: The<br>n.<br>After this certificete hi<br>funeral director, page   | 2              | 1 ☑ Yes 2 ☐ No  27. Manner of Death  |   | atient 2 ER/Outpatie                             |   | 4 🗆 Nursing                                       |                                      | how injury occurred                       | Specify)  |
|            | ding<br>After<br>fune  | Certification: | 1 □Natural 5 □ Pending   | 28a. Date of Ir<br>(Month, L                                      |  | Wor   | k?<br>Yes 2.2No                                   | 280. Describe                        | FA1 i                                     |   |
| Division   | or Attending<br>after death.<br>Director: After<br>in by the fune  | fica           | 3 ☐ Suicide 6 ☐ Could not  | be 28e. Place of  | Day Jody UNKA                                    | קנטיו   |   | 28f. Location                        | (Street and Number of                     | or Rural Route Number,  |
| Div        | al or J  | erti           | 4 Homicide   | GENES   | etc. (Specify)                                   | ELL NURSI   | LV. HOME  | 2 -                                  | EMGE RD                                   | , PARKVILLE . ME  |
|            | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   |                | (Check only 2 Medical Ex   | Physician: To the beaminer: On the basis                          | st of my knowledge, dea<br>of examination and/or | ath occurred at the tir                                     | ne, date and place                                | ce, and due to the                   | cause(s) and manne                        | or as stated.   |
|            | the hin 2 the l  | Medical        | 29b. Signature and title of certifier  | and manner  | stated.  | 29c. Licens   | e number  |                                      | 29d. Date signed (M                       | fonth Day Year)   |
|            | To Too   |                | 255. Signature and this of think   | MAN N   | $\sim$   |   | 0692  | 39                                   |   |   |
|            | \  |                | 30. Name and address of person wh  | 1 (1770)  | f death (Item 23a) (Type                         |   | 1) Pad  |                                      | VCCCT 195R                                | +2 400x   |
|            | V  |                | MAW NAINO  |   |  | SAMARITA  | and Abo   | DITAL:                               | BALTIMAR                                  | 2005 a, MD  |
|            | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year) DEC 3 0 2  | 32. Regi  | strar's Signature                                | nes   | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,           |                                      |   |   |

JEAN STEVENS

|                     |   |                    | 1 - State of Maryland  | d / Department of Health and Me<br>Certificate of Death  | ental Hygie                               | 211115 127714  |
|---------------------|---|--------------------|--|--|---|--|
|                     | Physicia  |                    | Decedent's Name (First, Middle, Last)     Jane D. Simms  |  | 2. Date of Death<br>Month<br>December     | Day Year 3. Time of Death 1000 M                                 |
|                     | /Medic<br>Examin  |                    | 4a. Facility Name (If not institution, give street and number) HCR - MONOCOOP III WOST   | - Rd 4b. City, Town, or Location of Death  |   | Baltimore Count  |
|                     | Funeral<br>Director   |                    | 5. Social Security Number  6. Sex  1 M 2 XF  7. Age (In yrs. Ia  Usual Residence of Decedent   | Yrs. Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Ye       | 9. Birthplace (State or Foreign Country) Mary Land               |
|                     | Maryland<br>f show  | or                 |  | Town or Location  Baltimore  |   | 10d. Inside City Limits<br>1 X Yes 2 ☐ No                        |
|                     | with the P<br>a or 28a-<br>Les notif  | Director           | 10e. Street and Number 15 N. Gilmor Street   | 10f. Zip Code<br>21223   | 10g.                                      | Citizen of What Country? USA                                     |
| စ္တ                 | after death<br>or items 23  | by Funeral         | 11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  1 Never Married 2 Married If Yes, Give If Yes, Give  |  | cify Yes or No-<br>tican, etc.)           | 14. Race - American Indian, Black, White, etc.  Specify:         |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatih and Mentall Hygiene. Importent: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, In. Medical Evan har must be notified at once. | Completed by       | 3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of workin<br>life. DO NOT use retired)   | g 168                                     | Black b. Kind of Business/Industry                               |
| and 21              | l be filed wit<br>ntal Hygien<br>ed other th<br>event, Ibe  | Be                 | 12 17. Father's Name (First, Middle, Last)   | Macine Operator  18. Mother's Name   |   | Mail Plant<br>(den Sumame)                                       |
| Maryle              | 12 should<br>and Mer<br>Is mark<br>reumatic   | 2                  | Joseph Diggs  19a. Informant's Name/Relationship (Type, Print)   | 19b. Mailing Address (Street and Number or Rural   |   |  |
| Baltimore, I        | ages 1 and<br>out of Health<br>t: If item 2<br>y or other 1   |                    | 1 Burial 2 □ Cremation 3 □ Removal from State  | metery, crematory or other place)  | ate 200                                   | c. Location - City or Town, State                                |
| Baltir              | permit. P<br>Departme<br>Importen<br>any injur  |                    | 21. Signature of Funeral Service Licensee  | Zion Cemetery 12-31-0 22. Name and Address of Facility Wylie Funeral Home P.A. 6                                 |   | nsdowne, MD or St. Balto, MD 21217                               |
|                     | Physician<br>/Medical<br>Examiner   |                    | 23a Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a  | Do not enter the mode of dying, such as cardiac or renal farlure   | respiratory arrest,                       | Approximate Interval Between Onset and Death 2 Yv 1              |
|                     | icate be executed<br>physicien and<br>s the burial-transit  | dical Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c. Due to (or as a consequence) | levotic Cardio vascular  | 100                                       | hyllocacus) zwks   |
|                     | The law requires that the death certificat attending phy atte has been signed by the attending phy page 2 should be detached for use as the   | by Physician/Media | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | death 3 Ectopic pregnancy  |   | 23d. Date of delivery<br>Month Day Year                          |
| rds, P              | quires that<br>n signed build be deta   | d by Pi            | Part II. Other significant conditions contributing to death but not resul  | ting in the underlying cause given in Part I.  |   | co use contribute to the cause of death?                         |
| al Reco             | :: The law requir<br>cate has been si<br>; page 2 should i  | Completed          |  |  | 24a. Was an autopsy performed 1 Yes 2     |  |
|                     | nding Physicien: Th<br>tth:<br>:: After this certificate<br>e funeral director, pag   | atlon: To Be       |  | 26. Place of Death  ER/Outpatient 3 DOA Other: 4 Nursing Hom  28b. Time of Injury at Work?  M 1 Yes 2 No         |   |  |
| Divis               | tel or Attendi<br>s after death<br>al Director: A<br>ad in by the f   | Certification:     | 3 Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify)   | ne, farm, street, factory, office  | Bf. Location (Stree<br>City or Town, S    | et and Number or Rural Route Number,<br>State)                   |
|                     | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral   | edical             | 29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my know 2☐ Medical Examiner: On the basis of examination and manner stated.   | vledge, death occurred at the time, date and place, ar<br>on and/or investigation, in my opinion, death occurred | nd due to the caus<br>d at the time, date | e(s) and manner as stated.<br>and place, and due to the cause(s) |
| ŀ                   | To To 1   | Σ                  | 29b. Signature and title of certifier  Mientoon Kidune,  | 29c. License number 0 3 1 8 6 5  |   | Date signed (Month, Day, Year)  2 / 2 6 / 0 5                    |
| _                   | Y   |                    | 30. Name and address of person who completed cause of death (Item  Rm 2 t 6 SZ ( N. Widas  |  | md  | 2/20/  |
|                     | Sta<br>Registr  |                    | 31. Date filed (Month, Day, Year)  DEC 3 0 2005  32. Prijstrar's Signatu   | w street Bretinure   |   |  |

| For                   |                 | State              | e Oi Ivia            | rylanu .      | -   | inment of F   |          |                 | пеппат пу      | gie  |                    | 15             | 42219                   |
|-----------------------|-----------------|--------------------|----------------------|---------------|---|---|----------|-----------------|----------------|------|--------------------|----------------|-------------------------|
| State Registrar       |                 |                    |                      |               | Cer   | tificate of t   | Death    | 1               |                | Reg. | No.                | / 13           |                         |
| 1. Decedent's Name    | (First, Middle  | e, Last)           |                      |               |   |   |          |                 | 2. Date of De  |      | D                  | .,             | 3. Time of Death        |
| Darrell I             | Ray Tay         | <del>rlor</del> D  | arrel                | l Roy         | Tag   | ylor  |          |                 | Month          |      | Day<br>20          | Year           | 0.00 - M                |
| 4a. Facility Name (II |                 | 4b. City. Town, or | r Location           | of Death      | Decemb  | er  |          | 2005 9:29 a. "" |                |      |                    |                |                         |
| 976 Homb              |                 | -                  | ,                    |               |   | Essex Baltimo   |          |                 |                |      |                    |                | County                  |
| 5. Social Security N  | umber           | 6. Sex             |                      | (In yrs. last | birthday)                                     | If Under 1 Year   | If Under |                 | 8. Date of Bis | rth  | 1                  | 9. Birth       | place (State or Foreign |
| 220-80-80             | 038             | <b>X</b> ØM 2□     | F                    | 38            | Yrs.  | Months Days   | Hours    | Min.            | Nov. 16        |      |                    |                | land                    |
| Usual Residence of    | Decedent        |                    |                      |               |   |   | 4        |                 |                |      |                    |                |                         |
| 10a. State            | 10b. County     |                    |                      | 10c. City, T  | own or Lo                                     | cation  |          |                 |                |      |                    |                | 10d. Inside City Limits |
| Maryland              | Baltin          | nore               |                      | Esse          | €X  |   |          |                 |                |      |                    | 1 ☐ Yes 2 ⊋ No |                         |
| 10e. Street and Nur   | mber            |                    |                      |               |   | 10f. Zip Code   |          |                 |                | 10g. | Citizen of         | What Cou       | ntry?                   |
| 976 Hombe             | erg Ave         | enue               |                      |               |   | 21221 U.S.A.  |          |                 |                |      |                    |                |                         |
| 11. Marital Status    |                 |                    | Decedent E           | ver in U.S.   | 13. V   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian Btack, White, etc. |          |                 |                |      |                    |                |                         |
| 1 X Never Marri       | ed 2 Mari       | ied 1 🗆 Y          | es 2⊠N               | 0             |   |   |          |                 |                | Ви   | Btack, White, etc. |                |                         |
| 3 Widowed             | 4 Divorced      |                    | s, Give<br>or Dates: |               | 1 ☐ Yes 2X No Specify: Specify:               |   |          |                 |                |      | <sup>⊮y:</sup> Whi | .te            |                         |
| (Sago                 |                 | t's Education      | tod)                 | 1             | 6a. Deced                                     | lent's Usual Occup  | ation    | et af wark      | ina            | 16b  | . Kind of E        | Business/In    | dustry                  |
| Elementary/Seco       | <i>,</i> , ,    | <del>-</del>       | ge (1-4or 5-         | 4)            | life. L                                       | OO NOT use retired  | d)       | or work         | n ig           |      |                    |                |                         |
| 12                    | ician           |                    |                      |               | Wa  | aste  | Treat    | ment Plant      |                |      |                    |                |                         |
| 17. Father's Name     | (First, Middle, | Last)              |                      | 18. Moth      | er's Nam                                      | e (First, Middle  | , Mai    | den Suma        | ımə)           |      |                    |                |                         |
| Arlie R.              | Taylo           | -                  |                      |               | Caro  | lyn   | I. Zahr  | ada             | aka            |      |                    |                |                         |
| 19a. Informant's Na   | ame/Relations   | hip (Type, Print)  |                      |               | 19b. Mailin                                   | 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |          |                 |                |      |                    |                |                         |
| Arlie R.              | Taylor          | (Fathe             | r)                   | 9             | 976 Homberg Avenue, Baltimore, Maryland 21221 |   |          |                 |                |      | 21221              |                |                         |

20b. Place of Disposition (Name of cemetery, crematory or other place)

**Physician** /Medical

permit. Pages 1 and 2 sh Depertment of Heelth and Important: # Item 27 ien eny injury or other treun once.

item 27 is marked other then "neturel; or items 23a or 28a-f show other treumatic event, the Medical Examiner must be motified as

Baltimore, Maryland 21215-0036

Be Completed by Funeral Director

2

20a. Method of Disposition

1X Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

Examiner

Examiner Completed by Physician/Medical Be Certification: To

Medical

State Registrar

burial-transit the attending physicien and as the esn ò detached signed by been si page 2 this certificete tilled in by the funeral director. within 24 hours after deat To the Funeral Director:

The law requires thet the death certificate be executed

To the Hospitel or Attending Physician:

Division of Vital Records, P.O. Box 68760,

| 21. Signature of Funeral Sealing   | Bruzdzinsk   | i Funeral Home, P<br>Avenue, Essex, Ma | .A.<br>cyland 2122                                 |
|--|--|--|--|
| 23a. Part 1. Early the disease, or show, or heart failure. List tmmediate Cause (Final   | complications that caused the death. Do not enter the mode of dying, such as cardiac only one cause on each line.                        | or respiratory arrest,                 | Approximate<br>Intervat Between<br>Onset and Death |
| disease or condition resulting in death)   | Heroin, Ethanol, and Cocaine Intoxication  Due to (or as a consequence of):  |  |  |
| Sequentially list conditions, if any, Isaumy to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or as a consequence of):  |  |  |
| resulting in death) Last   | Due to (or as a consequence of):   |  |  |
| tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  | 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) | 23d. Date of di<br>Month               | elivery<br>Day Year                                |
| Part II. Other significant condition   | ons contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute        | to the cause of death?                             |

25. Was case referred to medical examiner?

5 Pending \_\_investigation

6 Could not be

1 Yes 2 □ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 🗌 Homicide

Hospital: 1 ☐ Inpatient 28a Date of Injury Fnd (Month, Day Year)

Found at home

12/28/05

2 ER/Outpatient 3 DOA 28b. Time of 28c. tnjury at Work?

1 🗌 Yes 2**7** No

Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) At SCENE 28d. Describe how injury occurred

autopsy performed?

1⊠Yes 2□No

24a. Was an

1 ☐ Yes 2 ☐ No

unk

26. Place of Death Check only one

Holly Hill Mem. Gard. Jan. 2,2006 Baltimore, Maryland

28f. Location (Street and Number or Rural Route Number City or Town, State) 976 Hamberg Ave. Essex, MD

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No

20c. Location - City or Town, State

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

9:25 A

29d. Date signed (Month, Day, Year)

OCME

December 29, 2005

cause of death (Item 23a) (Type, Print) 111 Penn Street 30. Name and address of person who completed Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

DEC 3 n 2005



JOHN TURNER Please Type or Print in Black Indelible Ink./Finsure All Copies Are Legible.

Amend/Unpend item#23,PII,24a,b,27,26a I,Pentiple Ink./Finsure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene UNK 05-8440 AKG 62216 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 14, John Paulson Turner **Physician** 8:20 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner West Cold Spring Lane & Wabash Avenue Baltimore 3 8 1 n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 59 Months Days Hours Sept. 28,1946 Pennsylvania Yrs. 159-38-0113 **Director** Usuat Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b Counts 10d. Inside City Limits rai', or iteme 23a or 28a-f ehow Examiner must be notified at Maryland Baltimore 1 ☐ Wes 2 ☐ No Funeral Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3706 W. Rogers Avenue 21215 United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) r then Elementary/Secondary (0-12) College (1-4or 5+) Computer Tape Librarian Allied Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental le marked William Donald Turner Pearl Elizabeth Paulson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Turner (Brother) 527 Yarmouth Road, Towson, MD 21286 nt of Health a : If item 27 le 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of important: If eny injury or once. Bayview Crematory 12/22/05 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furreral Service Licensee Brian T. Chisholm runeral Services of Dulaney Valley, P.A. M01113 200 E. Padonia Road, Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atherosclerotic Cardiovascular Disease complicated by Hypothermia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sa uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Mental illness, unspecified Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2/No death? 2□ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Scene examiner? 1XYes 2 □ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred Exposure to 27. Manner of Death Find (Month, Day Year) Find Injury 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 ☐ Yes 27 No investigation low environmental temperature death. Director: / d in by the f 12/14/05 8?15 A 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Bural Route Number, City or Town, State) West Coldspring @ Wabash Ave. Baltimore, M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours after To the Funeral Dire Found in field 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (uneck only one) A Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME December 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HROL 111 Penn Street Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year)

DEC 3 0 2005

32. Registrar's Signature

|                           |   |                | For<br>State<br>Registrar   | State of  | Maryland                              | •                           | rtment o                        |                         |                                   | -                               | giene<br>Reg. No | UUD  | 422                     | 217          |
|---------------------------|---|----------------|---|---|---------------------------------------|-----------------------------|---------------------------------|-------------------------|-----------------------------------|---------------------------------|------------------|--|-------------------------|--------------|
|                           | Physici   | on.            | 1. Decedent's Name (First, Middl  | e, Last)  |                                       |                             |                                 |                         |                                   | 2. Date of De<br>Month          |                  | <sup>y</sup> 2005 <sup>Year</sup>              | 3. Time                 |              |
|                           | /Medic  |                | Verna   |   |                                       |                             |                                 |                         |                                   | Dec.                            |                  |  |                         | PM           |
|                           | Examin  | er             | 4a. Facility Name (If not institution   |   |                                       |                             | 4b. City, Tov                   | wn, or Loc              | ation of Death                    |                                 | 40               | . County of Deat                               |                         |              |
|                           | ·   |                | Gilchrist Nui 5. Social Security Number   |   | e <b>r</b><br>7. Age (In yrs. las     | t hirthday)                 | TO                              | wson                    | Jnder 24 Hrs.                     | 8. Date of Bi                   | th               | Baltimo  | re Co.                  | or Foreign   |
|                           | Funeral Director  |                |   | 1 M 2 R F   |                                       | Yrs.                        |                                 |                         | ours Min.                         | (Month, Da                      | iy, Year)        |  | hplace (State<br>untry) |              |
|                           | Director  |                | 198-20-7039 Usual Residence of Decedent   |   | 77                                    |                             |                                 |                         |                                   | April                           |                  | 928 Pen  | nsylva                  | nıa          |
| Plan                      | yland   |                | 10a. State 10b. County  |   | 10c. City, 7                          | Town or Lo                  | cation                          |                         |                                   |                                 |                  |  | 10d. Inside             |              |
| 213                       | Mar<br>6-1-   | ctor           | Maryland F  | Baltimore   |                                       |                             |                                 |                         | Es                                | sex                             |                  |  | 1 ∐ Y€                  | s 2 🛭 No     |
| 1                         | death with the Marylan<br>me 23a or 28e-f show<br>rinual be notified at   | Director       | 10e. Street and Number  |   |                                       |                             | 10f. Zip Co                     | de                      |                                   |                                 | 10g. Ci          | tizen of What Co                               | ountry?                 |              |
| S                         | 23a   | a              | 1900 Grove Mar  |   |                                       |                             |                                 |                         | 21221                             |                                 |                  | United   |                         |              |
| 22/                       | r dea   | Funeral        | 11. Marital Status  |   | dent Ever in U.S.<br>rces?            | 13. \                       | Was Decedent<br>f Yes, specify  | t of Hispar<br>Cuban, M | nic Origin? (Sp<br>exican, Puerto | ecify Yes or No<br>Rican, etc.) | )-               | <ol> <li>Race - Ame<br/>Black, Whit</li> </ol> |                         |              |
| 36                        | s afte  | by F           | 1 ☐ Never Married 2 ☐ Mar<br>3 ☐ Widowed 4 ☐ Divorced   | If Yes, Giv   | Θ                                     |                             | I⊡Yes 2√∑                       | No Sp                   | oecity:                           |                                 |                  | Specify:                                       |                         |              |
| 2/c/                      | hour<br>tural   | ed t           |   | nt's Education                                      |                                       | 16a. Decec                  | dent's Usual C                  | ccupation               |                                   |                                 | 16b. K           | (ind of Business                               | White                   |              |
| 215                       | in 72<br>n "na<br>n "na   | Completed      | (Specify only highe   | st grade completed)  College (1                     |                                       | (Give                       | kind of work o                  | tone durin              | g most of work                    | ung                             |                  |  | ,                       |              |
| 1212                      | y with  | mo             | Elementary/Secondary (0-12)  12 Years   | College (1  | -40r 5+)                              | Of                          | fice M                          | anage                   | er                                |                                 |                  | Car Im   | ports                   |              |
|                           | othe  | Be C           | 17. Father's Name (First, Middle,   | Last)   |                                       |                             |                                 |                         |                                   | e (First, Middle                | , Maider         |  |                         |              |
| , 2 is                    | uld b<br>Menta<br>urked   | ToE            | Diegeo Delfi  | ino   |                                       |                             |                                 |                         | Julia                             | Mennit                          | i                |  |                         |              |
| Maryland Maryland         | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. To hours after 38 or 28e-1 show other treumatic event. If a Medical Examinar must be notified at   | v d            | 19a. Informant's Name/Relations   |   |                                       |                             | •                               |                         |                                   |                                 |                  | or Town, State, 2                              |                         |              |
|                           | and and m 27  |                | Mr. Frank G. 7  | rotta (Hu   |                                       |                             |                                 |                         |                                   | -                               |                  | .0 Essex                                       |                         | 21221        |
| /www.                     | permit. Pages 1 and 2 Deportment of Health a tmportant: If Item 27 is eny injury or other tre   |                | 20a. Method of Disposition  1 XBurial 2 Cremation   | 3 Removal from                                      | cen                                   | ce of Dispo<br>netery, cren | sition (Name in natory or other | or<br>r place)          | İ                                 | Date                            | 20c. L           | ocation - City or                              | Iown, State             |              |
| 7 =                       | Pa<br>tmen<br>tant:   |                | 4 Donation 5 Other (S   |   | Sac                                   |                             |                                 |                         |                                   | 12/27/2                         | 005              | Dundal   | k, Mar                  | yland        |
| Z = E                     | Depermit<br>Deper<br>Impor  |                | 21. Signature of Funeral Service  | Moensee   |                                       |                             | l. Name and A<br>da – Ruc!      |                         |                                   | one of                          | Dund             | lalk, Ir<br>Tand Z                             | C                       |              |
|                           | 40300   |                | 22 Part Fater the diagram   | Dec   | aused the death                       |                             |                                 |                         |                                   |                                 |                  | land 2   | 1222<br>Approxim        | ate          |
|                           |   |                | 23 Part1. Enter the disse, o shock, or heart lature. List Immediate Cause (Final                            | 2   |                                       |                             | _                               |                         | orr as cardiac                    | or respiratory e                | 11031,           |  | Interval B<br>Onset an  | etween       |
|                           | Physician<br>/Medical   |                | disease or condition resulting in death)  | _ a   | norcas                                |                             | Cana                            | er                      |                                   |                                 |                  |  | year                    | 3            |
| _                         | Examiner  |                |   | Due to (  | or as a conseque                      | nce or):                    |                                 |                         |                                   |                                 |                  |  | 586                     |              |
|                           |   | ē              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (   | or as a conseque                      | nce of):                    |                                 |                         |                                   |                                 |                  |  |                         |              |
| V                         | uted<br>d<br>ansit  | Examiner       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events                                | <b>S</b>  |                                       |                             |                                 |                         |                                   |                                 |                  |  |                         |              |
| ď                         | be executed<br>sicien and<br>burial-transit   | Exa            | resulting in death) Last  |   | or as a conseque                      | nce of):                    |                                 |                         |                                   |                                 |                  |  |                         |              |
| Box 68760                 | cate be ex<br>ohysicien<br>the burial   | ical           |   | d   |                                       |                             |                                 |                         |                                   |                                 |                  |  |                         |              |
| 99                        | ntifice<br>ing pr   | Med            | IF FEMALE:  |   |                                       |                             |                                 |                         |                                   |                                 |                  |  |                         |              |
| ĝ                         | eath certific   | lan/l          | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live b  | come of pregnand<br>irth 2 Petal d    | eath 3                      | Ectopic pregr                   |                         |                                   |                                 |                  | 23d. Date of de<br>Month                       | livery<br>Day           | Year         |
|                           | the e   | Physician/Med  | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4∐Pregn<br>9☐ Unkno                                 | ant at time of dea<br>own             | th 5∟                       | Other (speci                    | <i>ty)</i>              |                                   |                                 |                  |  |                         |              |
| 0                         | that the de<br>ad by the<br>detached  | P              | Part II. Other significant conditi  | ons contributing to de                              | eath but not result                   | ing in the u                | nderlying caus                  | se given in             | Part f.                           | 23e. Did                        | tobacco          | use contribute to                              | the cause o             | f death?     |
| <b>4</b>                  | signed<br>d be del  | d by           | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |   |                                       |                             |                                 |                         |                                   | 10                              | Yes 2            | . □ No 37 PI                                   | robably 4 [             | Unknown      |
| Š                         | w requir  | lete           |   |   |                                       |                             |                                 |                         |                                   | 24a. Wa                         | an               | 24b. Were at                                   | utopsy finding          | is available |
| B.                        | The lay   | Completed      |   |   |                                       |                             |                                 |                         |                                   | auto                            | psy<br>ormed?    | prior to death?                                | completion o            | cause of     |
| 7                         | icien: Th<br>certificate<br>ector, pag  | a              | 25. Was case referred to medica   | 1   |                                       |                             |                                 | 26                      | Place of Dea                      | 1 ☐ Yes<br>th (Check only       | 2 (AN            | o 1 ☐ Yes                                      | 2 □ No                  |              |
| <u> </u>                  | ysicie<br>is cert<br>direct   | To B           | examiner?<br>1 ☐ Yes 2 No   | Hospital:   | npatient 2 El                         | R/Outpatier                 | nt 3 DOA                        | 100                     |                                   |                                 |                  | 6 Other (Spe                                   | city) has               | Pica         |
| 2                         | ding Physicien: h. After this certific funeral director.  |                | 27. Manner of Death   | 28a. Date   | of Injury 2<br>th, Day Year) 2        | 8b. Time o                  | f 28c.                          | . Injury at<br>Work?    |                                   | 28d. Describe                   |                  |  |                         | 1.40         |
| . <u>.</u>                | uttendin<br>death.<br>ctor: Afi   | atlo           | Z L Mooldon   | igation   |                                       |                             | М                               |                         | 2 🗆 No                            |                                 |                  |  |                         |              |
| Division of Vital Records | r Atte  | Certification: | 3 Suicide 6 Could 4 Homicide determ   | nined 288. Place                                    | of Injury - At homing, etc. (Specify) | ie, farm, str               | reet, factory, o                | ffice                   |                                   | 28f. Location<br>City or To     |                  | nd Number or Ri<br>e)                          | ural Route N            | mber,        |
|                           | Hospitel or Attending Physicien: The law requires that the death certificate 44 hours after death. Funerel Director: After this certificate has been signed by the ettending physiteld in by the funeral director, page 2 should be detached for use as the |                |   |   |                                       |                             |                                 |                         |                                   |                                 |                  |  |                         |              |
|                           | To the Hospitel or Attendi<br>within 24 hours after death<br>To the Funerel Director: ¢<br>completely filled in by the h  | Medical        |   | ng Physician: To the<br>I Examiner: On the band man |                                       |                             |                                 |                         |                                   |                                 |                  |  |                         | a(s)         |
|                           | within 2<br>To the  | Me             | 29b. Signature and title of certific  |   | TOT STATEOU.                          |                             | 29c. L                          | icense nu               | mber                              |                                 | 29d. Da          | ate signed (Mont                               | n, Day, Year            | )            |
|                           | ⊢ s ⊢ ō   |                | Malia   | 1 / 110   |                                       |                             | T                               | ) (                     | 9303                              | ?                               | Dec              | ember  | -232                    | 2005         |
|                           | -   |                | 30. Name and address of person  |   |                                       |                             | Print)                          | /                       | ()                                |                                 |                  | cember   | 11                      |              |
|                           | 5   |                | MINITURE CO.  | nues, n   |                                       |                             | un                              | Vs 3                    | 10                                | mound                           | M                | 0 2120   | 4                       |              |
|                           |   | ate            | 31. Date filed (Month, Day, Year DEC 3  | 0 2005  | egistrar's Signatu                    | re A                        | sie!                            |                         |                                   |                                 |                  |  |                         |              |
|                           | Regist  | rar            | 0   | - LOUS FACE   | SAFEL SE                              | of the same                 |                                 |                         |                                   |                                 |                  |  |                         |              |

|  |                   | 1 - For<br>State<br>Registrar  | State of Marylan                                       |   | ent of Health and<br>ate of Death                                   | Mental Hygien                                 | UUU                         | 42218  |
|--|-------------------|--|--|---|---|---|-----------------------------|--|
|  |                   | Decedent's Name (First, Middle, Last)  |  |   |   | 2. Date of Death<br>Month Da                  | y Year                      | 3. Time of Death                                 |
| Phys<br>/Me  | dical             | SEYMON TE  | VELRAKH  |   |   | DECEMBER 2                                    | 27 2005                     | 1:15 P M   |
| Exan   | niner             | 4a. Fecility Name (If not institution, give st                               |  |   | ty, Town, or Location of Dea  | ath 4c  | c. County of Deat           |  |
|  |                   | 666 ST. GEORGES ST 5. Social Security Number 6. Sex                          | 7. Age (In yrs.  |   | STERSTOWN<br>der 1 Year   If Under 24 Hr                            | S. 8. Date of Birth                           | BALTIMO                     | RE   |
| Funer:<br>Directo  | _                 |  | M 2□F 70   | Yrs. Month  |   |   |                             | hplace (State or Foreign<br>buntry)<br>RUSSTA    |
|  |                   | Usual Residence of Decedent  |  |   |   | 100/20/1933                                   |                             |  |
| arylar   |                   | 10a. State 10b. County   |  | y, Town or Location                               |   |   |                             | 10d. Inside City Limits 1 ☐ Yes 2√☐ No           |
| he Ma<br>Ba-f  | ecto              | MD BALTIMO   | RE   | REISTERST   |   | 10= 0   | itings of Mines Co          | 1  |
| with t<br>a or 3   | Ö                 | 10e. Street and Number   | ATION DOAD   | 101.  | Zip Code  | 109. 0  | itizen of What Co           | ountry ?   |
| death with the Maryland<br>ms 23a or 28a-f show<br>Frust be notified at  | Funeral Director  | 666 ST. GEORGES ST   | 2. Was Decedent Ever in U.                             | .S. 13. Was De                                    | 21136<br>cedent of Hispanic Origin? (<br>pecify Cuban, Mexican, Pue | Specify Yes or No-                            | 14. Rece - Ame              |  |
| after o  |                   | 1 ☐ Never Married 2 ☑ Married  | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give              |   | pecify Cuban, Mexican, Pue<br>; 2 no <i>Specify:</i>                | erto Rican, etc.)                             | Black, White<br>Specify: Wh | e, etc.<br>∤ITE                                  |
| within 72 hours after mene.  The matural, or ite manical Executes  | d by              | 3 Widowed 4 Divorced   | Year or Dates:   | 10.10   | ZEINO Specify.  |   |                             |  |
| 72 h   | Completed         | 15. Decedent's Educ<br>(Specify only highest grade                           | ation<br>completed)                                    | 16a. Decedent's U<br>(Give kind of<br>life. DO NO | work done during most of w  | orking 16b. I                                 | Kind of Business/           | Industry   |
| withir Bene.   | dmo               | Elementary/Secondary (0-12)  | College (1-4or 5+)<br>5+                               | CIVIL EN  |   | co  | NSTRUCTI                    | ON   |
| ING Z IZ IS-UUSO  be filed within 72 hours after death with the Marylar be filed within 72 hours after death with the Marylar be filed with yielden I stanifer inval te notified at event, the Macilical Exemirer inval te notified at   | a                 | 17. Father's Name (First, Middle, Last)                                      | <u> </u>   | OTVIL LIV   |   | ame (First, Middle, Maide                     |                             | ·OIY   |
| hould be fill marked oth marked oth  | To B              | ZALMAN   |  | TEVELRA   | KH MARIA  | 4   | TF                          | REBUCH   |
| re, Maryla s 1 and 2 should if Health and Men item 27 Is marke other traumatic   |                   | 19a. Informant's Name/Relationship (Typ                                      | e, Print)  | 19b. Mailing Addr                                 | ess (Street and Number or F   | Rural Route Number, City                      | or Town, State, 2           | Zip Code)  |
| and and a mand a |                   |  | IFE  |   | GEORGES STATI   |   |                             |  |
| Ore<br>ges 1<br>t of H<br>in ite   |                   | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re                  | moval from State                                       | Place of Disposition (incremetery, crematory of   | or other place)   |   | ocation - City or           |  |
| L. Pages<br>tment of<br>tent: If i   |                   | '4 Donation 5 □Other (Specify)   |  | TIMORE HE   |   | 29/2005 REI                                   | STERSTOW                    | IN, MD   |
| Baltimore permit. Pages 1 Department of H Importent: If ite  | once              | 21. Signature of Funeral Service License                                     | 7  |   |   | OL LEVINSON                                   |                             |  |
|  |                   | 23a. Pert1. Enter the disease, or complic                                    | eations that caused the deat                           | h. Do not enter the n                             | REISTERSTOWN<br>node of dying, such as cardi                        | ROAD - PIK                                    | ESVILLE,                    | MDro21208  |
| Physicia   |                   | Immediate Cause (Final   | e cause on each line.                                  |   |   |   |                             | Onset and Death                                  |
| /Medic   |                   | disease or condition resulting in death)                                     | Due to (or as a conseq                                 | Uence of):  |   |   |                             | 14 MONTHS  |
| Examine  | er                | Sequentially list conditions b.  |  |   |   |   |                             |  |
| pe is  | iner              | f any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq                                 | uence of):  |   |   |                             |  |
| cate be executed physician and the burial-transit  | Examine           | that initiated events c.   | Due to (or as a conseq                                 | uence of):  |   |   |                             |  |
| 8/60<br>ate be e<br>hysician<br>the buria  | ale               | d  |  |   |   |   |                             |  |
| death certificate e attending physical for use as the  | edic              |  |  |   |   |   |                             |  |
| BOX 68 leath certific attending pl   | hyslcian/Me       | IF FEMALE: 23b. Was decedent pregnant 23                                     | c. If yes, outcome of pregna                           |   | pregnancy   |   | 23d. Date of del            |  |
|  | slois             | in the past 12 months? 1 □ Yes 2 □ No  | 4☐ Pregnant at time of d<br>9☐ Unknown                 |   |   |   | Month                       | Day Year   |
| - ± > or   | Phy               | 9 Unknown  Part II. Other significant conditions conf                        | tributing to death but not res                         | ulting in the underlyin                           | a cause given in Part I   | 23e Did tobacco                               | use contribute to           | the cause of death?                              |
| 8 8 8  | d by              | -  | induiting to dodn't but not not                        | and an and and any                                | g ozaso great in tally,   | 1 🔀 Yes 2                                     |                             | robably 4 Unknown                                |
| N > 0  | ompleted          |  |  |   |   | 24a. Was an                                   | 24b. Were au                | atoosy findings available                        |
| has has  |                   |  |  |   |   | autopsy<br>performed?                         | death?                      | utopsy findings available completion of cause of |
| VITAL F ician: Th certificate rector, pag  | O                 | 25. Was case referred to medical   |  |   | 26. Place of D  | 1 ☐ Yes 2 ☑ No                                | ) ILl tes                   | 2□ No  |
| 00   | ToB               | examiner?<br>1 ☐ Yes 2 ☑ No  | ospital: 1   Inpatient 2                               | ER/Outpatient 3                                   | Othors  | Home 5 🔀 Residence                            | 6 □Other (Spe               | cify)  |
|  |                   | 27. Manner of Death 1 SNatural 5 ☐ Pending                                   | 28a. Date of Injury<br>(Month, Day Year)               | 28b. Time of<br>Injury                            | 28c. Injury at<br>Work?   | 28d. Describe how inju                        | iry occurred                |  |
| VISION Attending r death. ector: After   | catic             | 2 Accident investigation 3 Suicide 6 Could not be                            |  | М   | 1 Yes 2 No  |   |                             |  |
| DIVISION  Tor Attending after death. Director: After tin by the fune   | Certification:    | 4 Homicide determined  | 28e. Place of Injury - At he<br>building, etc. (Specif | ome, farm, street, lac<br>fy)                     | tory, office  | 28f. Location (Street a<br>City or Town, Stat | nd Number or Ru<br>e)       | ural Route Number,                               |
| spital<br>ours a<br>nerel I  | ညီ                |  | ician: To the best of my kno                           | owledge, death occur                              | ed at the time, date and ola  | ce, and due to the cause(s                    | s) and manner as            | s stated.  |
| e Hos<br>24 h<br>e Fur   | edical            | (Check only 2 Medical Exemin   | er: On the basis of examina<br>and manner stated.      | ation and/or investigat                           | ion, in my opinion, death oc  | curred at the time, date an                   | d place, and due            | to the cause(s)                                  |
| DIVISIO  To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fi   | ×                 | 29b. Signature and title of certifier  | D.   |   | 29c. License number   |   | ate signed (Monti           |  |
|  |                   | 1/4 (43)   | socrate 1 1101   | 75502)  | D33759  | Dso   | EMBER                       | - 27,2005  |
| 10   |                   | 30. Name and address of person who con UNWERSTRY OF MAR                      | npleted cause of death (Item                           | n 23a) (Type, Print)                              | ARIF HUSSA  | am, us  |                             | 11 0   |
| - 2  | State             | 31. Date filed (Month Day Year)  | Y LAND CAREED  | BAUM CA   | NEEL CENTER   | - 225. GREGE                                  | NE DT, P                    | MALTIMORE MO 2120                                |
|  | <del>ગ</del> ાવાલ | DEC 3 0 2  | Managara A   | 11. 2004  |   |   |                             |  |

|             |   | •                   | For<br>State<br>Registrar   | State of Maryla  |                                    | artment of<br>tificate of            |  |                                       | giene<br>2005                        | 42219  |
|-------------|---|---------------------|---|--|------------------------------------|--------------------------------------|--|---------------------------------------|--------------------------------------|--|
|             | Physici   | 20                  | 1. Decedent's Name (First, Middle, Last   | 1                                    |                                    |                                      |  | 2. Date of Dea<br>Month               | ath<br>Day Year                      | 3. Time of Death                                 |
|             | Physici<br>/Medic   |                     | faulette  | VVICKS   |                                    |                                      |  | 12                                    | 25 2005                              | 2236 M   |
| 7           | Examin  | ner                 | 4a. Facility Name (If not institution, give   | street and number)   | Hospital                           | 4b. City, Town,                      | or Location of Deat                      | in                                    | Ac. County of Dea                    |  |
|             | Funeral   |                     | 5. Social Security Number 6. Se   |  | s. last birthday)                  | If Under 1 Yea                       | If Under 24 Hrs                          |                                       | h 9. Bir                             | thplace (State or Foreign                        |
|             | Director  |                     | 218-42-3213   | □M 2Q1F 61   | Yrs.                               | Months Day                           | s Hours Min.                             | (Month, Day<br>1-28-19                | 44 Mary                              | land   |
|             | pug *   |                     | Usual Residence of Decedent  10a. State 10b. County   | 10c. (   | City, Town or Lo                   | cation                               |  |                                       |                                      | 10d. Inside City Limits                          |
|             | f eho   | jo                  | Maryland Montgomery   |  | encervill                          |                                      |  |                                       |                                      | 1 X Yes 2 ☐ No                                   |
|             | r 28a-  | rect                | 10e. Street and Number  |  |                                    | 10f. Zip Code                        | )  |                                       | 10g. Citizen of What Co              | ountry?  |
|             | th with   | a D                 | 16600 Batson Road   |  |                                    | 20868                                |  | U                                     | nited States                         | America  |
|             | tems  | nner                | 11. Marital Status  | 12. Was Decedent Ever in<br>Armed Forces?                                  | U.S. 13.                           | Was Decedent of<br>f Yes, specify Cu | f Hispanic Origin? (Suban, Mexican, Puer | Specify Yes or No-<br>to Rican, etc.) | 14. Race - Ame<br>Black, Whit        |  |
| 36          | rs afte   | by Funeral Director | 1 Never Married 2 Married 3 Widowed 4 Divorced  | 1 □ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:                           |                                    | 1 □ Yes 2 <b>火</b> □ N               | o Specify:                               |                                       | Specify: Wh                          | ite  |
| 21215-0036  | within 72 hours after death with the Maryland<br>one.<br>then "neturel", or Items 23e or 28e-f ehow<br>the Medical Exercities must be rediffed at   | ted                 | 15. Decedent's Edu  | ucation  | 16a. Deced                         | ient's Usual Occ                     | upation                                  | dina                                  | 16b. Kind of Business                | /Industry  |
| 218         | ithin 7<br>19.  | Completed           | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5+)   | life.                              | DO NOT use reti                      | ne during most of wo<br>red)             | rking                                 |                                      |  |
|             | filed w<br>Hygier<br>other th   |                     | 12. 17. Father's Name (First, Middle, Last)   |  | Home                               | maker                                | 19 Mother's Na                           | me /First Middle                      | Own Home  Maiden Sumame)             |  |
| anc         | should be filed within and Mental Hygiene. marked other then matic event, Italia  | o Be                | Paul R. Thompson  |  |                                    |                                      | Ann A. L                                 |                                       | walden Sumame)                       |  |
| Maryland    | s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 is marked other then "neturel", or items 23s or 28s-1 ehow other treumatic event. If a McJical Exaction must be rediffed at   | J.                  | 19a. Informant's Name/Relationship (T)  | ype, Print)  | 19b. Mailir                        | ng Address (Stre                     | et and Number or R                       | ural Route Numbe                      | or, City or Town, State, .           | Zip Code)  |
|             | and 2<br>eaith a<br>n 27 is   |                     | Merrill Wicks/husband   | d  | 16600                              | Batson Ro                            | ad, Spencer                              | ville, Mar                            | yland 20868                          |  |
| Baltimore,  | permit. Pages 1 and 2 s<br>Department of Health an<br>Importent: If item 27 is<br>any injury or other treu<br>once.   |                     | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F   | I  | . Place of Dispo<br>cemetery, crer | sition (Name of<br>natory or other p |  | Date                                  | 20c. Location - City or              |  |
| ţ           | tront of tent: If it  |                     | ' 4 □ Donation 5 □ 9ther (Specify)  | ) N  | lational (                         |                                      | i  |                                       | alls Church,                         | Virginia   |
| Ba          | permit. Pa<br>Departmer<br>Importent:<br>eny injury<br>once.  |                     | 21. Signature of Funeral/Service Licens   | 1.011  |                                    |                                      | fress of Facility F1                     |                                       | l Home<br>Maryland 2070              | 7  |
|             |   |                     | 23a. Part1. Ent. The disease, or comp   | lications that caused the de   |                                    |                                      |  |                                       |                                      | Approximate                                      |
|             | Physician   |                     | shock, or heart failure. List only o<br>Immediate Cause (Final<br>disease or condition                      | NA.  | Dean.cl                            | Into                                 | reton                                    |                                       |                                      | Interval Between<br>Onset and Death              |
|             | /Medical  |                     | resulting in death)   | a<br>Due to (or as a cons  |                                    | 11 0                                 | - 0,70,7                                 |                                       |                                      |  |
|             | Examiner  | L.                  | Sequentially list conditions,   | b. Qualo (or es a cons   | one +                              | uter 0                               | SCLIC                                    |                                       |                                      |  |
|             | nsit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Sala to (or da a corra   | aquerius ory                       |                                      |  |                                       |                                      |  |
| ó           | execu<br>an and<br>rial-tra   | Exa                 | that initiated events<br>resulting in death) Last   | Due to (or as a conse  | equence of):                       |                                      |  |                                       |                                      |  |
| 8760,       | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit  | dlcal               |   | d  |                                    |                                      |  |                                       |                                      |  |
| 9           | entification of the second of |                     | IF FEMALE:  | 22a If you sutages of prog   |                                    |                                      | -  |                                       | · ·                                  |  |
| Вох         | that the death certification by the attending properties as   | Physician/Me        | in the past 12 months?  | 23c. If yes, outcome of preg<br>1☐Live birth 2☐Fe<br>4☐Pregnant at time of | etal death 3                       | Ectopic pregnan<br>Other (specify)   |  |                                       | 23d. Date of de<br>Month             | ivery<br>Day Year                                |
| P.O.        | the d   | Jysle               | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 9□ Unknown   |                                    | g out of (opposity)                  |  |                                       |                                      |  |
|             | w requires that the<br>been signed by th<br>should be detache   | Jy Pl               | Part II. Other significant conditions co  |  |                                    |                                      | given in Part I.                         | 23e. Did to                           | obacco use contribute to             |  |
| ord         | equire<br>sen sig   | ted                 | Chronic Op  | structive Lung   | Viscose                            |                                      |  | 1 ETY                                 | ′es 2□No 3□Pi                        | obably 4 Unknown                                 |
| Records,    | aw<br>Is b  | Completed by        |   |  |                                    |                                      |  | 24a. Was autop                        | sy prior to                          | itopsy findings available completion of cause of |
| <u>=</u>    | Th<br>ate<br>pag  |                     |   |  |                                    |                                      |  | 1 Yes                                 | 2 No 1 ☐ Yes                         | 2 No   |
| Vital       |   | o Be                | 25. Was case referred to medical examiner?  | Hospital: 1 ☐ Inpatient 2  | <b>ER</b> /Outpatien               | t 3 DOA                              | other                                    | ath (Check only of                    | ne)<br>lence 6 □Other (Spe           | cife)  |
| of          | g Phys<br>er this<br>eral di  | n: To               | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)                                   | 28b. Time of                       | 28c. In                              |  |                                       | ow injury occurred                   | unyy   |
| ion         | Attending r death. sctor: After y the fune  | atlo                | 1 Natural 5 Pending investigation   |  | mjury                              |                                      | ☐Yes 2☐No                                |                                       |                                      |  |
| Division of | or Atter<br>ter de<br>irecto  | Certification:      | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of Injury · At building, etc. (Spe                              | home, farm, str<br>cify)           | eet, factory, offic                  | 8  | 28f. Location (S<br>City or Tow       | Street and Number or Ri<br>m, State) | ural Route Number,                               |
|             | To the Hospital or Attending is within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | I Ce                | 29a. Certifier 1 Certifying Phy   | sician: To the best of my k  | nowledge death                     | occurred at the                      | time date and plan                       | a and due to the                      | rause(s) and manner as               | stated   |
|             | e Hos<br>124 h(<br>e Fun<br>letely  | Medical             | (Check only 2 Medical Exam  | iner: On the basis of exami<br>and manner stated.                          | nation and/or in                   | vestigation, in my                   | y opinion, death occ                     | urred at the time, o                  | date and place, and due              | to the cause(s)                                  |
|             | To th<br>withir<br>To th<br>comp  | Me                  | 29b. Signature and title of certifier   |  |                                    |                                      | nse number                               |                                       | 29d. Date signed (Mont               |  |
|             |   |                     | ▶ KickWerst   | Omo  |                                    | U                                    | 142777                                   |                                       | December Z                           | 6, 2005  |
| _           | 10  |                     | 30. Name and address of person who c  | completed cause of death (It   | em 23a) (Type,                     | Print)                               | Olney, M                                 | coyland                               | 20832                                |  |
|             | Sta<br>Regist   | ate<br>rar          | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sig  | nature                             | 400                                  |  |                                       |                                      |  |

DHMH 17 Rev 1/2001

ORIGINAL

|  | •              | For<br>State<br>Registrar  | State of Maryland  |                             | artment of H   |   | _                               | giene<br>Reg. No. 05                        | 42220   |
|--|----------------|--|--|-----------------------------|--|---|---------------------------------|---|---|
| Dhysisia   |                | 1. Decedent's Name (First, Middle, Last)   |  |                             |  |   | 2. Date of De<br>Month          | ath<br>Day Year                             | 3. Time of Death                                  |
| Physicia<br>/Medica  |                | Joan M. West   |  |                             |  |   | Decemb                          | er 27 200                                   | 5 0225 AM   |
| Examine  | er             | 4a. Facility Name (If not institution, give s  |  |                             | 4b. City, Town, or   |   |                                 | 4c. County of Dea                           | ath   |
| Funeral  | - 1            | 5 Social Security Number 6 Sex   |  | st birthday)                | If Under 1 Year  | If Under 24 Hrs.                                  | 8. Date of Bir                  | th 9 Bi                                     | rthptace (State or Foreign                        |
| Director   |                | 214-30-3297  | м 2 <b>Ж</b> ғ 72  | Yrs.                        | Months Days  | Hours Min.  | Jul. 2                          | 5, 1933 M                                   | aryland   |
| and w  | -              | Usual Residence of Decedent  10a. State 10b. County  | 10c. City,   | Town or Lo                  | cation   |   |                                 |   | 10d. Inside City Limits                           |
| Maryli<br>-1 eho   | ট্             | MD Balti   | more   |                             | Lansdowne  |   |                                 |   | 1 ☐ Yes 2 X No                                    |
| death with the Marylanms 23a or 28a-f show   | Director       | 10e. Street and Number   |  |                             | 10f. Zip Code  |   |                                 | 10g. Citizen of What C                      | Country?  |
| th wit   | a D            | 326 5th Avenue   |  |                             | 2  | 21227   |                                 | United Sta                                  | ates  |
| J36<br>urs after of to the urs in the  | by Funeral     | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 2. Was Decedent Ever in U.S<br>Armed Forces?<br>1 ☐ Yes 2 M No<br>If Yes, Give<br>Year or Dates: |                             | Was Decedent of Hi<br>f Yes, specify Cuba<br>I □ Yes 2X No | spanic Origin? (Spin, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.) | 14. Race - Am<br>Black, Wh<br>Specify:      |   |
| 5-0036 72 hours at naturel, or   | Completed      | 15. Decedent's Educ<br>(Specify only highest grade   |  |                             | lent's Usual Occupa  |   | ina                             | 16b. Kind of Busines                        | s/industry  |
| d within giene.  | mp             | Elementary/Secondary (0-12)  | College (1-4or 5+)   | life. l                     | OO NOT use retired,  | ,   | 9                               | _   |   |
| a filed v<br>I Hygie<br>other ti   |                | 12 17. Father's Name (First, Middle, Last)   |  |                             | HO   | memaker   | e (First, Middle,               | Own<br>, Maiden Sumame)                     | Home  |
| E Sab  | To Be          | John William Llo   | yd   |                             |  |   |                                 | is Leona He                                 | aid1  |
| E SPEE   | -              | 19a. Informant's Name/Relationship (Type   |  | 19b. Mailir                 | g Address (Street a  |   |                                 | er, City or Town, State,                    |   |
|  |                | Walter West, Jr.   | Husband  |                             | 5th Avenu  |   |                                 |   |   |
| Ore<br>pes 1<br>of He<br>if item   | 1              | 20a Method of Disposition  ☐Burial 2 ☐Cremation 3 ☐R   | emoval from State  | metery, crer                | sition (Name of<br>natory or other place                   | 9)  | Date                            | 20c. Location - City o                      | r Town, State                                     |
| Baltimore, Depart. Pages 1 at Department of Hea mportent: If item any injury or othe                         | 1              | 4 Donation 5 Other (Specify)   | Loud   |                             | rk Cemete  |   |                                 | Baltimore                                   |   |
| Baltimore permit. Pages 1 Departrent of H. Important: If iter  |                | 21. Some une of Funeral Service Libense  | & What is  | The second                  |  |   |                                 | neral Home,                                 |   |
| -  |                | 23a. Part1. Enter the disease, or compli   | cations that caused the death.   |                             |  |   |                                 | Arbutus, MI<br>rrest,                       | Approximate                                       |
| Physician<br>/Medical  |                | shock, or heart failure. List only or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | Meta Static  |                             | east Ca  | ncer  |                                 |   | interval Between<br>Onset and Death<br>man ths    |
| Examiner   |                | Sequentially list conditions   |  |                             |  |   |                                 |   |   |
| . / P #  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury    | Due to (or as a conseque   | ence of):                   |  |   |                                 |   |   |
| 8760, Asate be executed only sician and the burial-transit   | Examiner       | that initiated events resulting in death) Last   | Due to (or as a conseque   | ence of):                   |  |   |                                 |   |   |
| 8760,<br>ate be ex<br>hysician<br>the burial   | dicai E        |  |  |                             |  |   |                                 |   |   |
| 68/<br>ifficate<br>g phy:<br>as the  | edic           |  | •  |                             |  |   |                                 |   |   |
| that the death certificate be executed by the attending physician and detached for use as the burial-transit | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                        | 3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of decentions    | death 3□                    | Ectopic pregnancy Other (specify)                          |   |                                 | 23d. Date of de<br>Month                    | elivery<br>Day Year                               |
|  |                | Part II, Other significant conditions con  | tnbuting to death but not resul  | lting in the u              | nderlying cause give                                       | en in Part I.                                     | 23e. Did t                      | obacco use contribute                       | to the cause of death?                            |
| Records, he law requires t e has been signe age 2 should be o  | Completed by   | Hyper Kalemia  |  |                             |  |   | 10                              | Yes 2 No 3 ₽                                | Probably 4 Unknown                                |
| aw recase is been 2 short  | piet           | Acute renal fa   | lare   |                             |  |   | 24a. Was                        | an 24b. Were a                              | autopsy findings available completion of cause of |
| The lav  | E              |  |  |                             |  |   | perfo                           | ormed? death?                               |   |
| r Vital Reysician: The is certificate hadirector, page   | Be             | 25. Was case referred to medical examiner?   |  |                             | Lau  | 26. Place of Deatl                                |                                 |   |   |
| 0 5 5 5  | 2              | 1 ☐ Yes 2 ☑ No 27. Manner of Death   |  | R/Outpatier<br>28b. Time of | t 3 DOA  | 4 Nursing Ho                                      |                                 | dence 6 Other (Sp                           | ecify)  |
| After funer  | Certification: | 1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be                                     | (Month, Day Year)  | Injury                      | M 1 🗆 Y  | Yes 2 □No   |                                 | how injury occurred  Street and Number or F | Pural Pauta Number                                |
| DIVISION Hospital or Attended to the four after death Funeral Director: tely filled in by the                |                | 4 Homicide determined  | building, etc. (Specify)   |                             |  |   | City or To                      | wn, State)                                  | 2015/03/2015/2015                                 |
| To the Hospital or within 24 hours after To the Funeral Direction  | ledical        | (Check only 2 Medical Examinations)  | sician: To the best of my knowner: On the basis of examinati and manner stated.                  | on and/or in                | vestigation, in my op                                      | pinion, death occur                               | ed at the time,                 | date and place, and du                      | e to the cause(s)                                 |
| To To  | Σ              | 29b. Signature and title of certifier  |  |                             | 29c. License   |   |                                 | 29d. Date signed (Mor                       | nn, Day, Year)                                    |
| í  | ı              | Mohammed   | MD   | 22a) (Tuna                  | PIT  | 601   | 7                               | December 2                                  | 17,2005   |
| V  |                | 30. Name and address of person who co  |  |                             | venue R  | 5216  | EM.                             | 21228                                       |   |
| Sta  | te             | Naree3a Mohammed 31. Date filed (Month, Day, Year)   | 32. Registrar's Signati  |                             | TOTAL L  | - Climore   | 11-12                           |   |   |
| Registra   |                | DEC 3 0 20   | 05   | e fin                       | ach o  |   |                                 |   |   |
| DHMH 17 Rev 1/20   | 01             |  | 1-00000 70   | Popular                     |  |   |                                 |   |   |
|  |                |  |  | ORIGII                      | VAL  |   |                                 |   |   |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** -28,2005 19:44 eauber DOROTHY ESTELLE YATES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A BALTIMORE UNION MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, AUG 15 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Country)
PENNSYLVANIA 1 □ M 2XXF Yrs. 80 1925 220-12-7985 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County 10c. City, Town or Location 10a State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or iteme 23a or 28a-f show ury or other traumatic event, the Medical Examment must be notified at 1 ▼Yes 2 No Director BALTIMORE MARYLAND N/A 10g. Citizen of What Country? 10e. Street and Number U.S.A. APT 217 21201 524 N CHARLES STREET Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ☐ Widowed 4 ☒ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPREME LIFE INSURANCE AGENT 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LUCY E SCOTT ROBERT H YATES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other trai once. 1735 Ashburton St., Baltimore, Maryland 21216 Robert H Yates/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS MEMORIAL 01-04-06 HALRIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Surrey Service 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part 1. Solve the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Syndrome **Physician** /Medical Due to (or as a consequence of) Examiner Enducardat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s 1 ☐ Yes 2 ☐ No 2 No 1 Yes or Attending Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ M6 Certification: To 28d. Describe how injury occurred After thi Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 1 Natural 1 Tyes 2 No within 24 hours after death.

To the Funeral Director: All
completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memoria 32. Registrar's Signature State Registrar 2005

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Rosalee December Day 2, 2005 Aikens 7:15AM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6414 Horseshoe Road Clinton Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 2 K Director 577-32-4406 Yrs. 85 JUNE 13 1920 SOUTH CAROLINA Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location ehow 10d. Inside City Limits ir than "natural", or items 23a or 28a-f ehov The Medical Exeminer must be notified at Director MD PRINCE GEORGE'S 1 X Yes 2 No LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7835 MICHELE DRIVE permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Heelth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a any njury or other traumatic event, the Medical Examinat must once. 20785 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced BLACK Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th TECHNICIAN GOVERNMENT 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) PETER AIKENS GOODWIN MARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7835 MICHELE DRIVE LANDOVER, MARYLAND 20785 MELVIN AIKENS/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 12/19/05 SUITLAND, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria FerryRoad Clinton, MD 20735 40 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician V0/6 Months /Medical Due to (or as a consequence of): Examiner Lehro Aculan Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events Due to (or as a consequence of): Examine nding physicien and use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No atten for u 23d. Date of delivery requires that the death 3 □Ectopic pregnancy 2 □ Fetal death Day 4☐Pregnant at time of death Month Year signed by the a d be detached for P.O. 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown The law 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 20 No certificate of Vital 1 ☐ Yes To the Hoepital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Division Natural 5 Pending Injury 2 Accident investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-12-2005 173226 who completed cause of death (Item 23a) (Type, Print) Richard Feldman MD 9500 Annapolis Road A-4 Lanham, Maryland 31. Date filed (Month, Day, Year) . Registrar's Signature State DEC 1 6 2005 Registrar

|                   |  |                  | 1 - For State Registrar  | State of Maryland  |                              | rtment of H   |                                 | and Mental Hy  | giene                               | 05 42223   |
|-------------------|--|------------------|--|--|------------------------------|---|---------------------------------|--|-------------------------------------|--|
|                   | Physic<br>/Medi  |                  | 1. Decedent's Name (First, Middle, Las.<br>Grace Maymon Ar   | ngle   |                              |   |                                 | 2. Date of De Month                                  | Day                                 | Year 3. Time of Death  |
| 100               | Exami  | ner              | 4a. Facility Name (If not institution, give  | Ospital  |                              | 4b. City, Town, or  | n                               |  | 4c. Count                           | ty of Death  |
| 30                | Funeral<br>Director  |                  | 040 45 55 5  | 7. Age (In yrs. last 94  | Yrs.                         | Months Days   | If Under<br>Hours               | 8. Date of Bir<br>Min. 3 – 28 – 1                    | 19 (1)                              | 9. Birthplace (State or Foreign<br>Baltimore, Md                       |
|                   | Maryland<br>e-f show   | ctor             | Md 10b. County Talbot  |  | own or Loc<br>Micha          |   |                                 |  |                                     | 10d. Inside City Limits 1 ☐ Yes X☐ No                                  |
|                   | th with the 23a or 28  | Funeral Director | 10e. Street and Number 24580 Deep Wate   | er Point Road  |                              | 10f. Zip Code<br>21663  |                                 |  | 10g. Citizen of USA                 | What Country?  |
| 920               | 72 hours after death with the Maryland<br>natural', or Items 23a or 28e-f show<br>after Examiner must be multified at                          | by               | 11. Marital Status  1 Never Married 2 Married  3 XVidowed 4 Divorced   | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1Yes_2 [X]No<br>If Yes, Give<br>Year or Dates:                 |                              | as Decedent of His<br>Yes, specify Cubar<br>Yes 210 No          | spanic Origin, Mexican Specify: | gin? (Specify Yes or No<br>, Puerto Rican, etc.)     |                                     | ce - American Indian,<br>ick, White, etc.<br>fy: White                 |
| 21215-0036        | within<br>ane.<br>than "   | Completed        | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>12 years  | le completed)  College (1-4or 5+)  | (Give k.<br>life. Di         | ent's Usual Occupa<br>ind of work done di<br>O NOT use retired) | uring most                      | of working   | 16b. Kind of B                      | Business/Industry  |
| Maryland          | should be filed<br>and Mental Hygid<br>marked other<br>matic event, til  | To Be C          | 17. Father's Name (First, Middle, Last) Salvatore Maymo  | on   |                              |   | 18. Mother                      | r's Name (First, Middle,<br>arine Ros                | Maiden Sumar<br>S                   | πε)  |
|                   | permit. Pages 1 and 2 should b<br>Department of Health and Mente<br>Important: if item 27 is marked<br>eny injury or other traumatic e<br>one. |                  | 19a. Informant's Name/Relationship (7)  Jennifer A. Dun  20a. Method of Disposition  |  |                              | Address (Street at 835 Mart tion (Name of                       | nd Number<br>Lingl              | nam Circl  |                                     |  |
| Baltimore,        | nit. Pages<br>artment of<br>ortant: if it<br>injury or o   |                  | 1 ☐ Burial 2 【XCremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)<br>21. Signature of Funeral Service Licens:   | Removal from State Cap   | itory, crema<br>itol         | Cremato  Name and Address                                       |                                 | 12-19-200  |                                     | -City or Town, State<br>er, Γε.  |
| B                 | permi<br>Depa<br>Impo<br>eny ir  |                  | 23a. Part1. Enter the disease, or conto  | Having ications that caused the death D  |                              |   |                                 |  | roet                                | Approximate  |
|                   | Physician<br>/Medical  |                  | shock, or heart failure. List only or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | ie cause on each line.   | is ho                        | <b>1</b> .  | 9                               | d Alle   | 4 .                                 | Approximate<br>Interval Between<br>Onset and Death                     |
| 58760,            | ficate be executed transit and the burial-transit and  | dical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence).  Due to (or as a consequence).   |                              | )e)   |                                 |  |                                     |  |
| O. Box (          | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as                              | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of pregnancy<br>1 □ Live birth 2 □ Fetal dea<br>4 □ Pregnant at time of death<br>9 □ Unknown |                              | ctopic pregnancy<br>Other (specify)                             |                                 |  | 23d. Dat                            | te of delivery<br>nth Day Year   |
| Records, P.       | w requires that<br>been signed b<br>should be deta   | þ                | Part II. Other significant conditions con  | tributing to death but not resulting   | g in the unde                | erlying cause given   | in Part I.                      | 23e. Did to  |                                     | ribute to the cause of death?  3  Probably 4 Unknown                   |
|                   |  | e Completed      | 25. Was case referred/o medical  | 542  |                              |   |                                 |  | med? d                              | Nere autopsy findings available prior to completion of cause of death? |
| <u> </u>          | d is X   | OB               | examiner?  | ospital: 1 Minpatient 2 ER/0   | Dutpatient                   | 3□ DOA Other:   |                                 | of Death Check only on<br>sing Home 5 Reside         |                                     | (0 (1)   |
| Division of Vital | Attending Ph<br>ir death.<br>ector: After th<br>by the funeral   | atlon: 1         | 27. Mann   f Death 1   atural   5   Pending   2   Accident   investigation   |  | . Time of<br>Injury          | 28c. Injury a<br>Work?  | 1 2 11010                       | 28d. Describe ho                                     |                                     |  |
| Š                 | oitel or Attendurs after death<br>oral Director:   | Certification:   | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home,<br>building, etc. (Specify)  |                              |   |                                 | City or Town   | n, State)                           | er or Rural Route Number.  |
|                   | To the Hospitel of within 24 hours af To the Funeral D completely filled in  | Medical          | one)   | ician: To the best of my knowledger: On the basis of examination a and manner stated.                            | ge, death or<br>and/or inves | algation, in my opin  | ilon, death                     | place, and due to the ca<br>occurred at the time, do | ause(s) and mar<br>ate and place, a | nner as stated.<br>and due to the cause(s)                             |
| 1                 | F X F S  |                  | 29b. Signature and title of certifier  | SunM   |                              | 29c. License n  | 87                              | 7  | 9d. Date signed                     | (Month/Day, Year)  |
| 1                 | (3)<br>Stai  |                  | 30. Name and address of person who cor<br>David H. Smith<br>31. Date filed (Manth. 29). Year 2005  |  |                              |   | East                            | con, Md. 2   | 21601                               |  |
|                   | Registra   | ar               | DE 0 2 0 Z005  |  | A COL                        | 27  |                                 |  |                                     |  |

Examiner

attending physician and for use as the burial-transit

ed by the detached

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this certificate has

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Director: Af

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| ri V d | Please Type or Print in Black Indelible Ink<br>item#23a,27,28a-f,penE.C51,1/4/06 II<br>State of Maryland / Department of I | c. Ensure All Copies Are Leg | jibl |
|--------|--|------------------------------|------|
| Unpena | State of Maryland / Department of I  | Health and Mental Hygiene    |      |
| 4.0    | 0 155 - 1 - 5  | 0.00                         | SE   |

e. Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day DECEMBER 9, Sandra Y. Anaya 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE"S HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 1□M 2\ F 28 El Salvador May 29, 1977 None Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Riverdale Maryland Prince George's Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5013 Oglethorpe Street 20737 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married 1 M Yes 2 □ No Specify: El Salvadorian Specify: Hispanic If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ٥ Antonio Fuentes Juana Alvarado 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5013 Oglethorpe Street, Riverdale, MD 20737 <u>Joe Rene Anaya - Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) MD National Memorial Park 12/19/2005 Laurel, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee audette I 4739 Baltimore Avenue, Hyattsville, MD 20781 ) anch 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Salicylate Intoxication disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? TV Yes 2 □ No 1□XYes 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No Certification: To 28a. Date of Injury 28b. Time of Injury Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural 1 Yes 2 No 12/9/05 2 Accident 3 Suicide investigation 11:10 K Subject ingested drug 6 Could not be determined 28f. Location (Street and Number of Rural Route Number, City or Town, State). 5013 Oglethorpe Street 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Residence Riverdale, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number hu, miD O.C.M.E. DECEMBER 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 LING LI M.D.

the Hospital or Attending Physicien: The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records.

State Registrar

31. Date filed (Month, Day, Year) DEC 2.0 2005 Registrar's Signature

|  | 1 - For<br>State<br>Registrar  | State of   | Marylar                          |                                    | artment of H<br>rtificate of L                                   |   | nd Mental Hygi  | ene<br>005                                    | 42226  |
|--|--|--|----------------------------------|------------------------------------|--|---|---|---|--|
| Physician<br>/Medical  | 2012/1   |  |                                  |                                    |  |   | 2. Date of Death<br>Month                               | Day Year OG Zaus                              | 3. Time of Death                                   |
| Examiner   | 4a. Facility Name (If not institution, g   | ive street and num   |                                  |                                    | 4b. City, Town, or   | TAS TA                                      | W.  | 4c. County of Dea                             |  |
| Funeral<br>Director  | 579-28-8645  | Sex<br>1 ☐ M <b>20</b> 0F  | 7. Age (In yrs.<br>100           | last birthday)<br>Yrs.             | If Under 1 Year<br>Months Days                                   | If Under 24<br>Hours                        | Min. (Month. Day.)                                      | 1905 Mond                                     | thplace (State or Foreign<br>ountry)<br>Cure NC    |
| Se-f show<br>diffed at   | Usual Residence of Decedent  10a. State  10b. County  MD  Prince G   | eorge's  |                                  | ty, Town or Lo                     |  |   |   |   | 10d. Inside City Limits<br>1⊠Yes 2 ☐ No            |
| 23a or 2<br>all be no  | 10e. Street and Number<br>3001 Queens Chap   | el Rd  |                                  |                                    | 10f. Zip Code<br>20712   |   |   | g. Citizen of What Co<br>ited State           | •  |
| ai, or items 23a or 28e-tsl<br>Exament must be notified<br>by Funeral Director   |  | 12. Was Dece<br>Armed For<br>1 Tes<br>If Yes, Give<br>Year or Da | ces?<br>2 🗽 No<br>e              |                                    | Was Decedent of Hi<br>f Yes, specify Cuba<br>1 ☐ Yes 2 🔯 No      | ispanic Origin<br>n, Mexican, F<br>Specify: | ? (Specify Yes or No-<br>Puerto Rican, etc.)            | 14. Race - Ame<br>Black, Whit<br>Specify: B13 | e, etc.  |
| Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23s or 28e-f show amportent: if item 27 is marked other than "natural", or items 23s or 28e-f show amportent in the Medical Examinat rusal be notified at once.  To Be Completed by Funeral Director   | 15. Decedent's (Specify only highest s Elementary/Secondary (0-12) 12  | Education<br>rade completed)<br>College (1                       | -4or 5+)                         | (Give                              | dent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | during most of                              | f working   | 6b. Kind of Business<br>rivate                | /Industry  |
| Mental Hygi<br>arked other<br>atic event, I  | 17. Father's Name (First, Middle, La.  | st)  |                                  | Nazbe                              |  | 18. Mother's                                | Name (First, Middle, Ma                                 | aiden Sumame)                                 |  |
| alth and h   | 19a. Informant's Name/Relationship<br>Winfred Battle/N   |  |                                  | 19b. Mailir<br>9 251 I             | g Address (Street a<br>Ceather H                                 | and Number of<br>ead Co.                    | or Rural Route Number, (<br>lumbia MD 2                 | City or Town, State, 2<br>1045                | Zip Code)  |
| ment of He<br>ent: If item<br>ury or oth   | 20a. Method of Disposition  1  |  | State Ha                         | cemetery, crer<br>rmony N          | sition (Name of<br>natory or other place<br>Iemorial             |   | -12-2005 T  | oc. Location - City or<br>andover MI          |  |
| Depart<br>import<br>any inj<br>once.   | 21 Signature of Funeral Service Lice   | ensee  | 20                               | 26                                 | Name and Addres  | ss of Facilit <b>P</b><br>Ave SE            | ope Funeral<br>Washington                               | Home<br>DC 20020                              |  |
| Medical<br>kaminer   | 23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | a  | O CAR                            | Quence of):                        | I NITARE   |   | rolac or respiratory arres                              | д,  | Approximate<br>Interval Between<br>Onset and Death |
| physician and the burial-transit   |  | c.  Due to (d  | or as a conseq                   | quence of):                        |  |   |   |   |  |
| ed by the attending placed tor use as the detached for use as the detached to the placed for the detached the detached for th | IF FEMALE: 23b. Was decedent pregnant in the past 12 monuts? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |  | rth 2 ☐ Feta<br>ant at time of c | al death 3                         | Ectopic pregnancy Other (specify)                                |   |   | 23d. Date of del<br>Month                     | ivery<br>Day Year                                  |
| P P P  | Part II. Other significant conditions  | contributing to de   | ath but not res                  | sulting in the us                  | nderlying cause give   | en in Part I.                               |   | cco use contribute to                         |  |
| certificate has been si<br>rector, page 2 should I   |  |  |                                  |                                    |  |   | 24a. Was an autopsy performe                            | prior to death?                               | topsy findings available completion of cause of    |
| this certitic<br>al director,<br>To Be (   | examiner?  | Hospital:  | npatient 2 🗷                     | ER/Outpatien                       | t 3□ DOA Othe  | · F   | Death Check only one                                    | ce 6 Other (Spec                              | cify)  |
| death, stor: After this, the tuneral dir ication: To   |  | on   | f Injury<br>n, Day Year)         | 28b. Time of<br>Injury             | 28c. Injury<br>Work<br>M 1 1                                     | at<br>?<br>/es 2 \( \text{No}               | 28d. Describe how                                       | injury occurred                               |  |
| Direction by   |  | d 289. Place<br>buildin  |                                  |                                    | eet, factory, office   |   | City or Town.   |   |  |
| within 24 hours a To the Funerel I completely filled Medical Ce  | (Check only 2   Medical Ex-  | hysician: To the<br>miner: On the ba<br>and mann                 | sis of examina                   | owledge, death<br>ation and/or inv | occurred at the time<br>restigation, in my op                    | e, date and p<br>pinion, death o            | lace, and due to the caus<br>occurred at the time, date | se(s) and manner as<br>a and place, and due   | stated.<br>to the cause(s)                         |
| To the comp  | 29b. Signature and title of certifier  | (  | mD                               |                                    | 29c. License   | number                                      | 290   | I. Date signed (Mont)                         |  |
| 2  | 30 Name and address of person wh   | Λ  |                                  |                                    | . N  | Jan.  | da.   | BIMES   | In wheek   |
| State<br>Registrar   | 31. Date filed (Month, Day, Year) DEC 1 3 70   | <b>≇</b> Re  | egistrar's Signa                 | -                                  | mb   | 1   |   |   |  |

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** KATHERINE **ADAMS** DEC. 10 2005 1:03PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAR . | 26 | 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) **Funeral** 1 □ M 2√2 F 86 Yrs. 577 40 8402 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Mudical Examinar must be notified at 10d, Inside City Limits MONTGOMERY SILVER SPRING MD. 1 X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12611 STRATFORD GARDEN DRIVE 20904 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3€ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other treumatic avent, the Maulangones. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) PVT. HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be **EDWARD** ROBINSON KATHERINE NEWTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEAH TAYLOR/NIECE 12611 STRATFORD GARDEN DR. SILVER SPRING MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State LINCOLN MEM. CEM. 1 XBurial 2 Cremation 3 Removal from State 12/14/05 SUITLAND MD. 4 □Donation 5 □ Other (Specify) 3435 14th ST., N.W. 20010 WATSON F. H. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIO PULMONARY ARREST Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of): Examiner the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical d use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ģ Month Year Day 5 Other (specify) o. detached þ α. The law requires thet Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES MELLITUS 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed Deen DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed this certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 No Physicien: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ₹ No 2X ER/Outpatient 3 □ DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending (Natural 5 Pending To the numbers of the death.

Within 24 hours efter death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 Hospitel 1 \*\* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 \*\*Distribution\*\*: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical one) å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 56147 12/14/05 30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) NASREEN KANGO M.D. 7610 CARROLL AVE., TAKOMA PARK MD. 20912 31. Date filed (Month, Day, Year) 82. Registrar's Signature State DEC 1 4 2005 Registrar

|                |   |                | 1 - For<br>State<br>Registrar   | State                         | of Maryland / D   |                  | artment of F                               |                          |  | gien      | 2005                                | 12228   |
|----------------|---|----------------|---|-------------------------------|---|------------------|--|--------------------------|--|-----------|-------------------------------------|---|
|                |   |                | Decedent's Name (First, Middle  | le, Last)                     |   |                  |  |                          | 2. Date of D                                     | eath      |                                     | 3. Time of Death                                    |
| П              | Physici<br>/Medio   |                | Donnie I  | Darnell Bo                    | owman   |                  |  |                          | Decemi   |           | ay Year 7 2005                      | 8 · 31 P M  |
|                | Examir  |                | 4a. Facility Name (If not institution   | n, give street and nu         | imber)  |                  | 4b. City, Town, or                         | Location of              |  |           | c. County of Dea                    |   |
|                |   |                | 1 Magna Way   |                               |   |                  | Westmins                                   |                          |  |           | Carroll                             |   |
| п              | Funeral   |                | 5. Social Security Number 214–80–2858   | 6.Sex<br>1 <b>XXM</b> 4 2 ☐ F | 7. Age (In yrs. last birt                                       | hday)<br>Yrs.    | If Under 1 Year<br>Months Days             | If Under<br>Hours        | Min. (Month, D                                   | ay, Year  | 7                                   | thplace (State or Foreign ountry)                   |
|                | Director  |                | Usual Residence of Decedent   |                               | 43  |                  |  |                          | Sept.  | 30,       | 1962                                | Maryland  |
|                | yland<br>yland  |                | 10a. State 10b. County  |                               | 10c. City, Town   | or Lo            | cation                                     | <del>-</del>             |  |           |                                     | 10d. fnside City Limits                             |
|                | a-fel   | ctor           | Maryland Car  | roll                          | Wes   | stm              | inster                                     |                          |  |           |                                     | 1 ☐ Yes 2X No                                       |
|                | or 28   | Director       | 10e. Street and Number  |                               |   |                  | 10f. Zip Code                              |                          |  | 10g. C    | itizen of What Co                   | ountry?   |
|                | ath w   |                | 298B East Gre   | en Street                     |   |                  |  | 21157                    |  |           |                                     | d states  |
|                | er de   | Funeral        | 11. Marital Status  | Armed F                       |   | 13.              | Was Decedent of H<br>f Yes, specify Cuba   | spanic Ori<br>n, Mexican | gin? (Specify Yes or N<br>i, Puerto Rican, etc.) | 0-        | 14. Race · Ame<br>Black, Whit       | erican Indian,<br>te, etc.                          |
| 36             | I', or  | by F           | 1 ☐ Never Married 2 ☐ Mar<br>3 ☐ Widowed 4 ☐ Divorced                         | IT YAS (5)                    | 24-100<br>ive   |                  | 1 ☐ Yes 2 No                               | Specify:                 |  |           | Specify: B                          | lack  |
| 21215-0036     | within 72 hours after death with the Maryland<br>ene.<br>then "netural", or Items 23a or 28a-f ehow<br>fra Mudical Examinar must be notilled at   | ted            | 15. Deceder   | t's Education                 | 16a.  |                  | dent's Usual Occupa                        |                          |  | 16b. F    | Kind of Business                    | /Industry   |
| 215            | hin 7   | Completed      | (Specify only higher<br>Elementary/Secondary (0-12)                           | st grade completed) Coflege ( |   | (Give<br>life. l | kind of work done of<br>DO NOT use retired | turing mosi<br>)         | t of working                                     |           |                                     | ,   |
| 2              | or the  | Соп            | 10th  |                               |   | Fo               | gles empl                                  | oyee                     |  | S         | Sanitatio                           | on  |
| Maryland       | be filed<br>tal Hygie<br>d other<br>event, il   | Be             | 17. Father's Name (First, Middle,   |                               |   |                  |  | 18. Mothe                | r's Name (First, Middle                          | , Maidei  | n <i>Sumame)</i>                    |   |
| <del>y</del> a | should<br>nd Men<br>marke<br>umatic   | 우              |   |                               | Rheubottom  |                  |  |                          | Edna Bow   |           |                                     |   |
| Nai            | 12 sh<br>h and<br>7 te m<br>treum   | 1              | 19a. Informant's Name/Relations   | hip (Type, Print)             | 19b.  |                  |  |                          | or or Rural Route Numb                           | -         |                                     | Zip Code)   |
|                | s 1 and 2 should be filed within 72 hours after death with the Marylan if health and Mental hygiene. Item 27 is marked other then "netural", or items 23a or 28a-f show other traumatic event, the Mudical Exercities must be notified at |                | Edna_Bowman_<br>20a. Method of Disposition                                    | mot                           |   |                  | JO Sams C<br>sition (Name of               | reek                     | Road West  |           | cter, MD                            | 21157   |
| <u>o</u>       | Pages<br>nent of<br>int: If It  |                | 1 ☐ Burial 2 ☑ Cremation<br>4 ☐ Donation 5 ☐ Other (S                         |                               | State cemetery  | v, cren          | natory`or other plac                       |                          | ry Dec. 9,                                       |           |                                     |   |
| altimore,      | # 문 <b>원</b> 등 .  |                | 21. Signature of Funeral Service  | License                       |   | 22               | . Name and Addres                          | s of Facilit             | v  |           |                                     | eld, MD   |
| ä              | Depa<br>Impo<br>any ii  |                | 23a. Pan . Enter the disease, or shirt to grant failure. List                 | (1)                           | auns  | Bu               | rrier-Qu                                   | een F                    | uneral Home                                      | ≥ & (     | Cremator                            | y, PA   |
|                |   |                | 23a. Part . Ent if the disease, or shick, or heart failure. List              | complications that            | caused the death. Do n  | ot ent           | er the mode of dying                       | J LID<br>g, such as      | Crty Road cardiac or respiratory a               | rrest,    | riera, i                            | Approximate Interval Between                        |
| E              | Pnysician   | 0 8            | Immediate ause (Final disease or condition                                    | SI                            | ateur U   | la               | als of                                     | - Non                    | Lard No  | ck        |                                     | Onset and Death                                     |
|                | /Medical<br>Examiner  |                | resulting in death)   | Due to                        | (or as a consequence o  | f):              | . 0 5 6 0                                  | 1100                     | cero ce 10                                       |           |                                     |   |
|                | LAdiminet   | <u>.</u>       | Sequentially list conditions,   | b                             | (or as a consequence o  | 0                |  |                          |  |           |                                     |   |
|                | ted<br>nsit   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | € Due to                      | (or as a consequence o  | 1):              |  |                          |  |           |                                     |   |
|                | al-tra  | xar            | that initiated events<br>resulting in death) Last                             | cDue to                       | (or as a consequence o  | f):              |  |                          |  |           |                                     |   |
| 8760,          | cate be executed<br>physicien end<br>the burial-transit   | dical          |   | L a                           |   |                  |  |                          |  |           |                                     |   |
| 9              | rtifical<br>ng ph<br>as th  | Φ †            | IE FELIALE  | 223                           |   |                  |  |                          |  |           |                                     |   |
| Вох            | eath certifi<br>ettending  <br>  for use as   | an/h           | IF FEMALE:<br>23b. Was decedent pregnant                                      |                               | tcome of pregnancy<br>birth 2 Fetal death                       | 3[               | Ectopic pregnancy                          |                          |  |           | 23d. Date of deli                   |   |
|                | at the dea<br>by the et   | Physician/M    | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                       |                               | nant at time of death   |                  | Other (specify)                            |                          |  |           | Month                               | Day Year  |
| P.0            | that the ed by detact   | F.             | Part fl. Other significant condition  | ORS contributing to d         | eath but not resulting in                                       | the ur           | dochring cauco guro                        | o in Bart f              | 220 Did  | obacca    | uso contribute to                   | the cause of death?                                 |
| Records,       | & 2 0   | d b            | , and a significant contains  | one contributing to d         | oddi oddiod i oddinig iii                                       | uio ui           | idenying cause give                        | ninirati.                |  |           | AZ.                                 | obably 4 Unknown                                    |
| cor            | w require<br>been sig<br>should b   | Completed      |   |                               |   |                  |  |                          |  |           |                                     |   |
| Be<br>Be       | : The law<br>cete has<br>page 2 s   | ошо            |   |                               |   |                  |  |                          | 24a. Was   |           | prior to death?                     | itopsy findings available<br>completion of cause of |
| Vital          |   | a              | 25. Was case referred to medica   |                               |   |                  |  | 26 Place                 | of Death Check only                              | 2 No      | Yes                                 | 2 □ No  |
|                | Physicien:<br>this certific<br>al director,   | ToB            | examiner?<br>XXYes 2 ☐ No   | Hospital:                     | Inpatient 2 ER/Out  | patien           | t 3 DOA Othe                               |                          | rsing Home 5 Res                                 |           | 61/7/Other (Spec                    | cify) Scene   |
| 0              | ding Ph<br>h.<br>After th<br>funeral  |                | 27. Manner of Death 1 □Natural 5 □ Pendin                                     | 28a. Date                     |   | me of            | 28c, Injury<br>Work                        |                          | 28d. Describe                                    |           |                                     | W Beerle  |
| Sio            | Attendil<br>death.<br>ctor: A<br>y the fu   | cati           | 2 Accident investi  | gation /2/                    | 1/05 200  | 21               | M 1 🗆 Y                                    | es 2                     | 00-0/1   | cit       | 875                                 |   |
| Division of    | or Att  | Certification: | 3 ☐ Suicide 6 ☐ Could determ  | ined 288. Mace                | of Injury - At home, fari<br>ing, etc. <i>(Specify)</i>         | m, stre          | eet, factory, office                       |                          | 28f. Location (<br>City or To                    | wn, State | e) / D                              | ral Route Number,                                   |
|                | Hospital or Attending Physicien:<br>44 hours alter death.<br>Funeral Director: After this certific<br>tely filled in by the funeral director,   |                | 29a. Certifier 1 ☐ Certifyir  | og Physician: To the          | The best of my knowledge  | dozth            | 70   | a data and               | d place and due to the                           | 4.7       | Ve/teni                             | N. Mre  |
|                | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the to  | Medicai        | (Check only 2 Medical one)  | Examiner: On the b            | best of my knowledge,<br>asis of examination and<br>ner stated. | or inv           | estigation, in my op                       | inion, deat              | h occurred at the time,                          | date and  | , and manner as<br>d place, and due | to the cause(s)                                     |
|                | To the Vithin 2 To the complet  | Me             | 29b. Signature and title of certifie  | r 10                          |   |                  | 29c. License                               | number                   |  | 29d. Da   | ate signed (Month                   | h, Day, Year)                                       |
|                | 12/11   |                | Mellor  | Kemil                         |   |                  | OCME                                       |                          |  | Dece      | ember 8,                            | 2005  |
|                | 3   | H              | 30. Name and address of person  | who completed caus            | se of death (Item 23a) (T                                       | Гуре, і          |  |                          |  |           |                                     |   |
|                |   |                | JAHON W   | JAC W                         | 4)  |                  | 111 Penr                                   | Stre                     | et Baltin  | ore,      | , Maryla                            | nd 21201  |
|                | Sta<br>Registr  |                | DEC 1   | 2 2005                        | leastrar's Signature  | ,                | hack .                                     |                          |  |           | - un-market                         |   |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No/ 1. Decedent's Name (First, Middle, Last) BRUBAKER 2. Date of Death Day Month **Physician** 505 PM JEAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs Social Security Number . Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 2 Director 408-44-5321 MAY 4, 1929 VA Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov event, the Medical Examiner must be notified at MD QUEEN ANNE'S Director STEVENSVILLE 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 330 FIVE FARMS DRIVE or items 23a 21666 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "naturel", or item sny injury or other traumatic event, the Mentales. Black, White, etc. 1 Never Married 2X Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Yas Give Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASSISTANT VICE PRESIDENT BANKING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JANNEY YATES **EUGENIA SNEED** 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM BRUBAKER/HUSBAND 330 FIVE FARMS STEVENSVILLE, MD 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) CHESAPEAKE CREMATION 12/15/2005 CHESTER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS HELFENBEIN & NEWNAM FUNERAL HOME 106 SHAMROCK ROAD CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final hemorrhage **Physician** Intracerebral /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 □Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 23 No certificate 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DQA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. (Check only one)

KC

State Registrar 29b. Signature and title of certiff

30. Name and address of person

DHMH 17 Rev 1/2001

leted cause of death (Item 23a) (Type, Print)

22.

32. Req

M.D

29c. License number

South Greene Street, Baltimore, Mayland 2120

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** DECEMBER 19 2005 <u>4:40</u> a <sup>M</sup> Senora Elizabeth Bentzel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**X**☐ F Yrs 91 April 22,1914 Pennsyl yania Director 213-09-7939 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show item 27 is marked other then "natural", or items 23a or 28a-f show other treumstic event, the Medical Exampler must be notified at 1 ☐ Yes 2 XNo Director Maryland St. Mary's Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25355 Allston Ln. 20636 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if tem 27 is marked other then "natural", or flem any injury or other treumatic event, the Medical Experience. 1 ☐ Yes 2 M No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coflege (1-4or 5+) Garment 10 Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Elizabeth Houser 2 William Agustus Bentzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donna Marie Barrick / Daughter 25355 Allston Ln. Hollywood, MD. 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/22/2005 Abbottstown, PA. Mt. Olive Cemetery 22. Name and Address of Facility Brinsfield Funeral Home P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons MO1206 22955 Hollywood Rd. Leonardtown, MD. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition neverthane Pnysician Tra cram resulting in death) /Medical Due to (or as a consequence of): Examiner Hynu tension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit Jones tra and Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE eşn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 Ectopic pregnancy jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached o 9□ Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by should be 4 Unknown 3 Probably 2 No 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending Division 1 Naturat 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: filled in by the 3 Suicide 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury · At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Hospitel or 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0060473 12000 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 25500 Point Lookout Rd. Leonardtown, MD. 20650 Mehrdad Akhlaghi MD. 32. Registrar's Signature State 1 9 Registrar

|                            |  |                   | For State   | State of Ma                                     | arylan        |                                 |                         |                          | lealth a<br>Death             | ınd Me                    |                                    | giene                   | 005                | 1,2231   |   |
|----------------------------|--|-------------------|---|---|---------------|---------------------------------|-------------------------|--------------------------|-------------------------------|---------------------------|------------------------------------|-------------------------|--------------------|--|---|
|                            |  | 8                 | Registrar  1. Decedent's Name (First, Middle, L   | ast)  |               |                                 | imoat                   | 0 01 1                   | Death                         |                           | 2. Date of Dea                     |                         | 000                | 3. Time of Death   |   |
| PE                         | Physici  |                   | Marie   | Josephine                                       |               | Burto                           | n                       |                          |                               |                           | Month<br>Decembe                   | Day                     | 6, 200             | r  |   |
|                            | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution, gr   |   |               | Burto                           |                         | Town, or                 | r Location of                 |                           | ресешь                             |                         | County of De       |  | _ |
| * 1                        | LAGITIT  | <b>*</b>          | St. Mary's  | Nursing Ce                                      | nter          |                                 |                         | Leon                     | ardto                         | wn                        |                                    |                         | St. M              | arv'e  |   |
|                            | Funeral  | 1                 |   | Sex 7. Ag                                       |               | ast birthday)                   | If Under                | 1 Year<br>Days           | If Under 2                    |                           | 8. Date of Birt<br>(Month, Da      | h<br>V Voarl            | 9. B               | hirthplace (State or Foreign<br>Country)   | ) |
| -85                        | Director   | 8                 | 577-03-2428   | 1□M 2∰F   | 95            | Yrs.                            | MOTITIES                | Days                     | Hours                         | IVIIII.                   | Jan. 13                            | 3, 1                    | 910 Wa             | shington, DC   | : |
|                            | pu 🔪   |                   | Usual Residence of Decedent  10a. State 10b. County   |   | 10c Cib       | , Town or Lo                    | eation                  |                          |                               |                           |                                    |                         |                    | 104 Incide On Living   | _ |
|                            | eho<br>eho   | 'n                |   |   | 100. 04       | ,, , o o . Lc                   | oation                  |                          |                               |                           |                                    |                         |                    | 10d. Inside City Limits 1 ☐ Yes 2 🖪 No   |   |
|                            | 28a-f  | Director          | Maryland St.  10e. Street and Number  | Mary's  |               |                                 | 10f. Zip                |                          | nue                           |                           |                                    | 10- 0%                  | zen of What (      |  |   |
|                            | with<br>a or   |                   |   | III D   | 1             |                                 | 101. 21                 |                          | 00                            |                           |                                    |                         |                    | •  |   |
|                            | eath   | by Funeral        | 39128 Cobru   | 12. Was Decedent                                |               | S 13 1                          | Was Decer               | 206                      |                               | nin? (Spec                | rfv Yes or No.                     |                         | nited S            | States nerican Indian.   | _ |
| <b>,</b>                   | r Iten   | Fun               | 1 ☐ Never Married 2 ☐ Married   | Armed Forces? 1 ☐ Yes 2 ☑ N                     |               |                                 | f Yes, spec             | cify Cuba                | in, Mexican,                  | Puerto R                  | ify Yes or No-<br>ican, etc.)      |                         | Black, Wh          |  |   |
| 93                         | urs a  |                   | 3 ₩idowed 4 Divorced  | If Yes, Give<br>Year or Dates:                  |               |                                 | 1□Yes                   | 2 No                     | Specify:                      |                           |                                    |                         | Specify: W         | hite   |   |
| Ö                          | 72 hours after death with the Maryland<br>natural', or items 23s or 28s-f ehow<br>dissi Essorinstrout be notified at   | Completed         | 15. Decedent's t  |   |               | 16a. Dece                       | dent's Usua             | al Occup                 | ation                         | of working                |                                    | 16b. Ki                 | nd of Busines      | ss/Industry  | _ |
| 21                         | e.<br>en .   | nple              | Elementary/Secondary (0-12)   | College (1-4or 5                                | 5+)           | life.                           | DO NOT u                | se retired               | during most                   | OI WOIKING                | ,                                  |                         |                    |  |   |
| 7                          | ed wi  | S                 | 12  |   |               | Assi                            | stant                   | to                       |                               |                           |                                    |                         | Educat             | tion   |   |
| 밀                          | be fit<br>tal H<br>d oth   | Be                | 17. Father's Name (First, Middle, Las   | t)  |               |                                 |                         |                          | 18. Mother                    | r's Name (                | (First, Middle,                    | Maiden                  | Sumame)            |  |   |
| Ş                          | ould<br>Men<br>Marke<br>Matic  | ဥ                 | Vincent Pau   |   |               |                                 |                         |                          |                               |                           | laire N                            |                         |                    |  |   |
| Maryland 21215-0036        | l 2 sh<br>and r<br>is m  | ĺ                 | 19a. Informant's Name/Relationship  |   |               |                                 | -                       |                          |                               |                           | Route Numbe                        | ,                       |                    |  |   |
|                            | permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any futury or other traumatic event, the Madical Exactinal must be notified at angle. |                   | Robert W. Burton 20a. Method of Disposition   | n II / So                                       |               | 3912<br>lace of Dispo           |                         |                          | <u>Whar</u>                   | f Roa                     | ad, Ave                            |                         |                    | 0609   | _ |
| آور                        | Pages<br>nent of I<br>ant: If Its  |                   | 1 ■ Burial 2 Cremation 3  |   | C             | emetery, crer                   | natory or o             | ther plac                |                               |                           |                                    |                         |                    |  |   |
| Baltimore,                 | it Printme   |                   | 4 Donation 5 Other (Spec  |   | Ced           | ar Hil                          |                         |                          |                               |                           |                                    |                         |                    | Maryland   | _ |
| Ba                         | Depa<br>Depa<br>Impo<br>any I  |                   | Mallinan  |   | MO            |                                 |                         |                          | ss of Facility                | DLTI                      | nsfield                            | d Fu                    | neral 1            | Home, P.A.   |   |
| N majorie                  | - S. S. S. S. S. S. S. S. S. S. S. S. S.   |                   | 23a. Part1. Enter the disease, or cor   | nplications that caused                         | the death     |                                 |                         |                          |                               |                           |                                    |                         | town, I            | MD 20650-027<br>Approximate  | 9 |
|                            | Dharisisa  |                   | shock, or heart failure. List ont   | y one cause on each lir                         | ne.           | · I                             |                         |                          |                               | -                         | ,                                  | ,                       |                    | Interval Between<br>Onset and Death  |   |
|                            | Physician<br>/Medical  |                   | disease or condition resulting in death)  | a. Due to (or as                                | 3 000000      | of acope                        |                         | リヒ                       | men                           | 119                       |                                    |                         |                    |  | _ |
| 1                          | Examiner   |                   |   | ì   | a consequ     | derice ory.                     |                         |                          |                               |                           |                                    |                         |                    |  |   |
|                            |  | Jer               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as                                | a consequ     | uence of):                      |                         |                          |                               |                           |                                    |                         |                    |  | _ |
|                            | outed<br>od<br>ransit  | Examiner          | that initiated events   | c   |               |                                 |                         |                          |                               |                           |                                    |                         |                    |  |   |
| ó                          | e exe  | EX                | resulting in death) Last  | Due to (or as                                   | a consequ     | uence of):                      |                         |                          |                               |                           |                                    |                         |                    |  |   |
| 8760,                      | death certificate be executed<br>e attending physicien and<br>id for use as the burial-transit   | Physician/Medical | •   | d   |               |                                 |                         |                          |                               |                           |                                    |                         |                    |  |   |
| 9                          | ing p  | Med               | IF FEMALE:  |   |               |                                 |                         |                          |                               |                           |                                    |                         |                    |  | _ |
| Вох                        | ath cuttend  | ian/              | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome 1 Live birth               | 2 Fetal       | death 3                         | Ectopic pr              |                          |                               |                           |                                    | 2                       | 23d. Date of d     | elivery<br>Day Year  |   |
| o.                         | res that the death certific<br>igned by the attending p<br>be detached for use as  | ysic              | 1 ☐ Yes 2 No<br>9 ☐ Unknown   | 4□Pregnant at<br>9□ Unknown                     | time of de    | eath 5                          | Other (sp               | ecity)                   |                               |                           |                                    |                         |                    | , , , , , , , , , , , , , , , , , ,  |   |
| Δ.                         | that the ed by detail  | / Ph              | Part II. Other significant conditions   | contributing to death b                         | ut not resu   | ulting in the ur                | nderlying c             | ause give                | en in Part I.                 |                           | 23e. Did to                        | obacco u                | se contribute      | to the cause of death?   | _ |
| ds.                        | The law requires that the<br>ste hes been signed by th<br>page 2 should be detache   | d by              |   |   |               |                                 |                         | _                        |                               |                           | 1 🗆 Y                              | 'es 2[                  | ]No 3∏!            | Probably 4 Munknown  |   |
| S                          | w require<br>been si<br>should I   | lete              |   |   |               |                                 |                         |                          |                               |                           | 24a. Was                           | 20                      | 24h Word           | autopsy findings available   | _ |
| æ                          | he lav<br>e hes<br>age 2   | Completed         |   |   |               |                                 |                         |                          |                               |                           | autop                              | sy<br>rmęd?             | prior to<br>death? | completion of cause of   |   |
| ta                         |  | e C               | 25. Was case referred to medical  | 1   |               |                                 |                         |                          | 26 Place                      | of Doath /                | 1 ☐ Yes<br>Check only o            | 2 No                    | 1 ☐ Ye             | os 2 No  | _ |
| <u> </u>                   | ysici<br>is cer<br>direci  | To B              | examiner?<br>1 □ Yes 2 No   | Hospital:                                       | nt 2 🗆        | ER/Outpatien                    | t 3 DC                  | Othe                     |                               |                           | e 5 Resid                          |                         | Other (Sc          | acity)   | _ |
| 0                          | Attending Physicien: r death. sctor: After this certificator, the funeral director,  |                   | 27. Manner of Death   | 28a. Date of Injur<br>(Month, Day               | ry<br>v Year) | 28b. Time of                    |                         | 8c. Injury<br>Work       |                               |                           | ld. Describe h                     |                         |                    | 56.197   | - |
| io                         | endir<br>path.<br>or: Af<br>he fur   | atlo              | Natural 5 Pending investigate   | on  | , , ,         | ,2.,                            | М                       |                          | Yes 2□N                       | lo                        |                                    |                         |                    |  |   |
| Division of Vital Records, | or Att   | Certification:    | 3 Suicide 6 Could not determined  |   | ury - At ho   | me, farm, str                   | eet, factory            | , office                 |                               | 28                        | If. Location (S<br>City or Tow     | itreet and<br>m, State) | Number or F        | Rural Route Number,  |   |
| Ω                          | rel D  |                   |   | -   |               |                                 |                         |                          |                               |                           |                                    |                         |                    |  |   |
|                            | To the Hospital or Attending F<br>within 24 hours after death.<br>To the Funerel Director: After<br>completely filled in by the funer  | edical            | 29a. Certifier 1 X Certifying P (Check only one) 2 Medical Exa  | hysician: To the best of miner: On the basis of | f examinat    | wledge, death<br>ion and/or inv | occurred<br>estigation, | at the tim<br>, in my or | ne, date and<br>pinion, death | l place, an<br>h occurred | d due to the d<br>d at the time, d | ause(s)<br>date and     | and manner a       | as stated.<br>ue to the cause(s)   |   |
|                            | thin S   | Med               | 29b. Signature and title of certifier   | and manner sta                                  | ated.         |                                 |                         |                          | number                        |                           |                                    |                         |                    | nth, Day, Year)  | _ |
| )                          | F F F S  |                   | - Deli  | als   |               |                                 | -50                     |                          | 1170                          | 66                        | (                                  |                         | 2.19               | Contract of the Contract of th |   |
| ,                          |  |                   | 30. Name and address of person who  | completed cause of i                            | oath (lta-    | 23a) (T==                       | Print'                  | )                        | 710                           |                           |                                    |                         | - 1                |  |   |
|                            |  |                   | Avani D. Shah, M  |   |               |                                 | ,                       | •+ т                     | _Anna~                        | dtor                      | n Max-                             | 71 0-                   | 4 204F             | 0  |   |
| 5,3                        | Sta  | te -              | 21 Date filed (Month Day Year)  | 20 80-1-44                                      | ar's Signat   | tuge d                          | مر ا                    | 1 و ما                   | lennar                        | u LOWI                    | u, Mary                            | утапо                   | 1 ZU03             | U  | - |
| *                          | Registr  |                   | DEC.20  | 2005  | -             | 0 A                             |                         |                          |                               |                           |                                    |                         |                    |  |   |

|                     |  |                | 1 - For<br>State<br>Registrar  | State of Ma  | arylan                      |                                 | artme           | ent of H                                 |                                      |  | lygien<br>Reg. N         | 200                      | ) 5                       | 42232  | bia |
|---------------------|--|----------------|--|--|-----------------------------|---------------------------------|-----------------|--|--------------------------------------|--|--------------------------|--------------------------|---------------------------|--|-----|
|                     | Physici<br>/Medi   |                | 1. Decedent's Name (First, Middle, Las<br>Margaret   | Mary   | Ва                          | rolet                           |                 |  |                                      | 2. Date of<br>Month<br>Decem           | Da                       |                          | Year<br>2005              | 3. Time of Death 12:30 a.M                         | m   |
|                     | Examir   |                | 4a. Facility Name (If not institution, give  | street and number)   |                             |                                 | 4b. Ci          | ty, Town, o                              | r Location of De                     |  |                          | c. County                |                           | 12133 41   |     |
|                     |  | 24             | St. Mary's N   |  |                             |                                 | Mille           |  | eonardt                              |  |                          | St.                      | Mar                       |  |     |
| k                   | Funeral Director   |                | 5. Social Security Number 6. Si 217–68–9407  | M 2∰F  | 90                          | ast birthday)<br>Yrs.           | Month           | der 1 Year<br>Is Days                    |                                      |  | Day, Year                | 15                       | 9. Birthpl<br>Count       | ace (State or Foreigr<br>try)<br>Lecticut          | ,   |
|                     | Aaryland<br>f ehow   | or             | 10a. State 10b. County   | •  | 10c. City                   | , Town or La                    |                 | 1.                                       |                                      |  |                          |                          | 10                        | 0d. Inside City Limits 1 ☐ Yes 2 ♣ No              |     |
|                     | the l  | Director       | Maryland St. M.  10e. Street and Number  | ary's  |                             |                                 |                 | onardi<br>Zip Code                       | town                                 | <u> </u>                               | 10g. C                   | itizen of W              | /hat Count                | try?   | _   |
|                     | h with   | al D           | 22680 Cedar Lane   | Court, Apt   | . #3                        | 102                             |                 | 206                                      | 550                                  |  |                          | nited                    |                           |  |     |
|                     | deat   | Funeral        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?                            |                             |                                 | Was De          |  |                                      | (Specify Yes or<br>erto Rican, etc.)   |                          | 14. Race                 | - America                 | an Indian,   |     |
| 036                 | 72 hours after death with the Maryland<br>natural', or Itama 23a or 28a-1 ehow<br>disal Examiner must be motified at   | by             | 1 ☐ Never Married 2 ☑ Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1 Yes 2 No<br>If Yes, Give<br>Year or Dates:                   | 10                          |                                 |                 | 2 No                                     | Specify:                             | erto Alcari, etc.)                     |                          | Specify:                 | k, White, e               | ite  |     |
| Maryland 21215-0036 | C 2  | Completed      | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  |  | +)                          | 16a. Deced<br>(Give<br>life. L  | kind of         | sual Occup<br>work done o<br>use retired | during most of v                     | working                                | 16b. i                   | Cind of Bus              | siness/Ind                | ustry  |     |
| 21                  | filed withi<br>Hygiene.<br>Ither then  | Con            |  | 4  |                             | Но                              | mema            | aker                                     |                                      |  |                          | Own                      |                           |  |     |
| Ind                 | be fill<br>ta! Hy<br>d oth   | Be             | 17. Father's Name (First, Middle, Last)  |  |                             |                                 |                 |  | 18. Mother's N                       | lame (First, Mide                      | dle, Maidei              | n Sumame                 | 9)                        |  |     |
| <u></u> ₹           |  | To             | Francis Jose   |  |                             |                                 |                 |  |                                      | y Rosali                               |                          |                          |                           |  |     |
| Mai                 | 12 s<br>h ar<br>7 le   |                | 19a. Informant's Name/Relationship (7  |  |                             |                                 |                 |  |                                      |  |                          |                          |                           | <sup>Code)</sup> 20650                             |     |
|                     | 1 an<br>Heali<br>am 2<br>ther  |                | John A. Barolet  20a. Method of Disposition  | / Husband  | 20b. Pl                     | ace of Dispo                    | sition /A       | lame of                                  |                                      | rt, Apt.                               |                          | .ocation - 0             |                           | dtown, MD  | _   |
| 2                   | 00   |                | 1 Burial 2 Cremation 3   |  | Ce                          | emetery, cren                   | natory`o        | r other plac                             | 1                                    |  |                          |                          | 1                         |  |     |
| Baltimore,          | 그 튼튼을  |                | 4 Donation 5 Other (Specify 21. Signature of Funeral Service   | \$99   | Lmma                        | aculat                          |                 |  |                                      | -27-2005                               |                          |                          |                           |  | -   |
| B                   | Depa<br>Impo<br>any it   |                | Edward N. Brinsfi  | eld, Jr.   | M0000                       |                                 |                 |  |                                      | Brinsfie                               |                          |                          |                           | ne, P.A.<br><u>20650-02</u> 79                     | ,   |
| A                   | Physician  |                | 23a. Part 1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition | lications that caused  | the death                   |                                 |                 |  | g, such as card                      |  | arrest,                  | 2 L                      |                           | Approximate<br>Interval Between<br>Onset and Death |     |
| \$                  | /Medical<br>Examiner   |                | resulting in death)  | Due to (or as a  | a consequ                   | ience of):                      |                 | <i>y</i>                                 |                                      |  |                          |                          |                           | <i>V</i> -   |     |
|                     | uted<br>d<br>ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | Due to (or as a  | aconsequ                    | ience of):                      | -               |  |                                      |  |                          |                          |                           |  | _   |
| 8760,               | sicien and<br>burial-transit   | Icai Exa       | resulting in death) Last   | Due to (or as a  | a consequ                   | ence of):                       |                 |  |                                      |  |                          |                          |                           |  |     |
| 687                 | ficate<br>physics file   |                |  | d  |                             |                                 |                 |  |                                      |  |                          |                          |                           |  | _   |
| P.O. Box            | The law requires that the death certificate be executed ate been signed by the attending physicien and bage 2 should be detached for use as the burial-transit | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown   | 23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown   | 2 🗌 Fetal                   | death 3                         |                 | pregnancy<br>specify)                    |                                      |  |                          | 23d. Date<br>Mon         |                           | ry<br>Day Year                                     |     |
|                     | signed by  | þ              | Part II. Other significant conditions of   | ontributing to death bu  | ıt not resu                 | Iting in the ur                 | nderlying       | cause give                               | en in Part I.                        |  |                          |                          |                           | a cause of death?                                  |     |
| Records,            | law requir<br>es been si<br>2 should   | oiete          |  |  |                             |                                 |                 |  |                                      | 24a. W                                 |                          | -                        |                           | sy findings available                              | -   |
| al Re               |  | Completed      | as w   |  |                             |                                 |                 |  |                                      | pe<br>1 ☐ Yes                          |                          | pr<br>de                 | ior to comeath?           | pletion of cause of                                |     |
| of Vital            | Physician: T<br>this certificet<br>ral director, pa  | o Be           | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital:  |                             | R/Outpatien                     |                 | Othe                                     |                                      | eath Check onl                         |                          |                          |                           |  |     |
| on of               | ing Phy<br>h.<br>After this<br>funeral d   | ion: To        | 27. Manner of Death 1 A Natural 5 ☐ Pending  | 28a. Date of Injur<br>(Month, Day                              | v                           | 28b. Time of<br>Injury          |                 | 28c. Injury<br>Work                      | at                                   | Home 5 Re<br>28d. Describ              |                          |                          |                           |  | -   |
| Division            | or Attending<br>affer death.<br>Director: After<br>in by the fune  | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Inju<br>building, etc                            | iry - At hor<br>. (Specify) | me, farm, stre                  | M<br>eet, facto |  | Yes 2 □ No                           | 28f. Location<br>City or 1             | (Street ar               | nd Number<br>e)          | r or Rural                | Route Number,                                      | _   |
|                     | To the Hospital or Attending Physicis within 24 hours effer death. To the Funaral Director: After this cert completely filled in by the funaral direct         | edical C       | 29a. Certifier 1 Certifying Phy<br>(Check only one) 2 Medical Exam   | ysicien: To the best of iner: On the basis of and manner state | examinati                   | vledge, death<br>ion and/or inv | occurre         | od at the time<br>on, in my op           | ne, date and pla<br>pinion, death oc | ice, and due to the curred at the time | ne cause(s<br>e, date an | ) and man<br>d place, ar | ner as sta<br>nd due to t | ited.<br>the cause(s)                              | _   |
|                     | To th<br>withir<br>To th<br>comp   | Me             | 29b. Signature and title of certifier  | _ /  |                             |                                 | 2               | 9c. License                              | number                               |  | 29d. Da                  | ite signed               | (Month, D                 | lay, Year)   |     |
|                     | 2  |                | · Who  | 1 for  | ~                           |                                 |                 | No                                       | 4285                                 |  | 1                        | 2                        | 21-                       | -01  |     |
| N 3                 | -)   |                | 30. Name and address of person who of William D. Boyd II   | (  |                             |                                 |                 |  |                                      | oonar 1+                               | 27.72                    | MD 20                    | 1650                      |  |     |
|                     | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  |  | r's Signat                  |                                 | 100             | NOUL                                     | nuau, L                              | eonaruc                                | JWII,                    | בות בנ                   | טכטי                      |  |     |

|                |  |                   | 1 - For<br>State<br>Registrar   | State of Marylar  | nd / Depa        |  |  | Mental Hyg                             | iene                                | 1.2233                                       |
|----------------|--|-------------------|---|---|------------------|--|--|--|-------------------------------------|--|
|                |  |                   | 1. Decedent's Name (First, Middle, Last)  |   |                  |  |  | 2. Date of Deat<br>Month               |                                     | 3. Time of Death                             |
|                | Physici:<br>/Medic   |                   | James Brow  | n   |                  |  |  | Decembe                                | Day Year<br>r 9 2005                | 17:43P M                                     |
|                | Examin   |                   | 4a. Facility Name (If not institution, give   | street and number)  |                  | 4b. City, Town,                        | or Location of Dea                       |  | 4c. County of Death                 | 1      |
|                |  |                   | Holy Cross Hos  | pital   |                  | S                                      | ilver Sp                                 | ring                                   | Montgo                              | merv   |
|                | Funeral  |                   | Social Security Number     6. Security Number   | 7. Age (In yrs.<br>XM 2☐ F                                  |                  | If Under 1 Year<br>Months Days         |  |  | Year) 9. Birthp                     | lace (State or Foreign                       |
|                | Director   |                   | 5/9-14-954/   | <b>A</b> M 20 F   | 6 Yrs.           |  |  | May 6,                                 |                                     | h., DC                                       |
|                | pun 🖈 🖰  |                   | Usual Residence of Decedent  10a. State 10b. County   | 10c Ci  | ty, Town or Lo   | ocation                                |  |  | T,                                  | Od Ipoida City I imite                       |
|                | sho  | <u></u>           | Tod. State  | 100.01  | ty, TOWN OF LO   | oation                                 |  |  |                                     | 0d. Inside City Limits 1                     |
|                | 8a-f   | Director          | DC  |   |                  | 1                                      | Washingt                                 |  |                                     |  |
|                | 72 hours after death with the Maryland<br>natural', or Hems 23s or 28s-f show<br>Jesal Exaller untile confliked at   | 늡                 | 10e. Street and Number  |   |                  | 10f. Zip Code                          |  | 10                                     | 0g. Citizen of What Coun            | itry?  |
|                | s 23   | ra                | 2732 Central  |   | 10 10            |  | 20018                                    |  |                                     | States                                       |
|                | irs after death wi   | Funeral           |   | 12. Was Decedent Ever in U<br>Armed Forces?                 | J.S.   13.       | Was Decedent of<br>If Yes, specify Cui | Hispanic Origin? (<br>ban, Mexican, Puei | Specify Yes or No-<br>rto Rican, etc.) | 14. Race - Americ<br>Black, White,  | etc.   |
| 36             | rs aft   | by F              | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ∰Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:             |                  | 1 ☐ Yes 2 ☐XNo                         | Specify:                                 |  | Specify.                            | rican  |
| 21215-0036     | n 72 hours aft<br>"natural", or  | edit              | 15. Decedent's Edu  |   | 16a Dece         | dent's Usual Dccu                      | ination                                  |  | 16b. Kind of Business/Inc           | erican                                       |
| 15             | C 2 0  | olet              | (Specify only highest grade   | e completed)  | (Give            | kind of work done DO NOT use retire    | during most of wo                        | orking                                 | TOD. RING OF BUSINESSYNC            | dostry                                       |
| 12             | filed within 72 ho<br>Hygiene.<br>Ither than "natur<br>ant, II a Weder   | Completed         | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                  |  | Special:                                 | ist                                    | Govern                              | ment   |
|                | H F F  |                   | 17. Father's Name (First, Middle, Last)   |   |                  |  | 18. Mother's Na                          | me (First, Middle, N                   | Maiden Sumame)                      |  |
| lan            | d ta d   | To Be             | Unknow  | n   |                  |  |  | Mah                                    | el Mercer                           |  |
| Maryland       | E B E E  | -                 | 19a. Informant's Name/Relationship (Ty  |   | 19b. Maili       | ng Address (Stree                      | et and Number or R                       |  | City or Town, State, Zip            | Code)  |
| Ž              | nd 2<br>ulth a<br>27 Ls<br>r tra   |                   | Anna Belle Brown  | - Wife  |                  |  |  |  | h., DC 2001                         |  |
| ē,             | s 1 en<br>if Heal<br>Item 2  |                   | 20a. Method of Disposition  | 20b.  |                  | esition (Name of<br>matory or other pl |  |  | 20c. Location - City or To          |  |
| e<br>E         | 0 - = =  |                   | 1 A Burial 2 □ Cremation 3 □ P  `4 □ Donation 5 □ Other (Specify)   |   |                  | n Nation                               | ,  | /23/2005                               | A 1 - 1                             | TTA  |
| Baltimore,     | permit. Pag<br>Department<br>Importent: I<br>any injury o  |                   | 21. Signature of Furreral Service License   |   |                  | II Nation  Name and Addr               |  |  | Arlingto<br>uneral Home             | on, VA                                       |
| B              | Dep Per  |                   | 1 JOHNT, S  | town IT TII   |                  |  |  |  | . Wash., DC                         | 20010  |
|                |  |                   | 23a. Part1. Enter the disease, or compl   | ications that caused the dea                                | th. Do not ent   |  |  |  |                                     | Approximate                                  |
|                |  |                   | shock, or heart failure. List only or<br>Immediate ause (Final<br>disease or condition                      |   | ibili 🕳 🔹        | - 4                                    |  |  |                                     | Interval Between<br>Onset and Death          |
|                | Pnysician<br>/Medical  |                   | disease or c. dition resulting in death)  | Pulmonar  Due to (or as a consec                            |                  | Lism                                   |  |  |                                     |  |
|                | Examiner   |                   |   | Choleyst  |                  |  |  |  |                                     |  |
|                | 100  | ē                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec                                      |                  |  |  |  |                                     |  |
|                | uted<br>d<br>ansit   | Examine           | Cause (Disease or injury that initiated events  | Pancreat  | itis             |  |  |  |                                     |  |
| Ć,             | exec<br>in an  | Exa               | resulting in death) Last  | Due to (or as a consec                                      |                  |  |  |  |                                     | _  |
| 8760,          | The law requires that the death certificate be executed the sabeen signed by the attending physician and page 2 should be detached for use as the buriat-transit | cal               |   | Metaboli  | c Ence           | phalopat                               | hy                                       |  |                                     |  |
| 9              | tificat<br>g phy<br>as th  | Physician/Medical |   |   |                  |  |  |  |                                     |  |
| Вох            | leath certifica<br>attending pt<br>I for use as t  | 2                 | IF FEMALE:<br>23b. Was decedent pregnant  | 3c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Fet      |                  | DEctopic pregnan                       |  |  | 23d. Date of delive                 | ry   |
|                | deat   | Cla               | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Pregnant at time of o                                     |                  | Other (specify)                        | cy .                                     |  | Month                               | Day Year                                     |
| P.0            | that the de<br>ed by the a<br>detached t   | hys               | 9 🗆 Unknown   | 9□ Unknown  |                  |  |  |  |                                     |  |
|                | es the<br>igned<br>be de   | by P              | Part II. Other significant conditions con   | ntributing to death but not re-                             | sulting in the u | nderlying cause g                      | iven in Part I.                          | 23e. Did tob                           | acco use contribute to the          | **   |
| pu             | w require<br>been sli<br>should l  |                   |   |   |                  |  |  | 1 □ Ye                                 | s 2 No 3 Prob                       | ably 42 Unknown                              |
| သွ             | law re<br>as be<br>2 sho   | plet              |   |   |                  |  |  | 24a. Was ar                            | 24b. Were autor                     | osy findings available inpletion of cause of |
| Vital Records, | The Is<br>ate ha<br>page 3   | Completed         |   |   |                  |  |  | autopsy<br>perform<br>1X Yes 2         | ned? death?                         | 2 No   |
| ita            | ician: Th<br>certificate<br>rector, pag  | BeC               | 25. Was case referred to medical  | <del></del>   |                  |  | 26. Place of De                          | eath (Check only one                   |                                     |  |
| <b>{</b> <     | S S  | ToE               | examiner?<br>1 ☐ Yes 2 🛣 No   | lospital: 1 XInpatient 2 □                                  | ER/Outpatier     | nt 3 DOA                               | ther: 4 🗆 Nursing I                      | Home 5 Reside                          | nce 6 Other (Specify                | •)   |
| n of           |  |                   | 27. Manner of Death  1 XNatural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)                    | 28b. Time o      | f 28c. Inju                            |  | 28d. Describe ho                       |                                     |  |
| Ö              | Attending or death. ector: Atter by the fune   | atic              | 2 Accident investigation  |   | ,,               |  | Yes 2 □ No                               |  |                                     |  |
| Division       | l or Attendente efter death<br>Director:   | Certification;    | 3 ☐ Sutcide 6 ☐ Could not be 4 ☐ Homicide determined  | 28e. Place of Injury - At h<br>building, etc. (Speci        | iome, farm, str  | eet, factory, office                   |  | 28f. Location (Str<br>City or Town     | reet and Number or Rura<br>, State) | Route Number,                                |
|                | rs efter or re efter or rel Dir  | Cer               |   |   |                  |  |  | ķī.                                    |                                     |  |
|                | Hospitel Pours Funerel Itely filled  | edical            | 29a. Certifier 1 Certifying Physical Check only 2 Medical Exami   | sician: To the best of my kn<br>ner: On the basis of examin | owledge, deat    | h occurred at the t                    | time, date and plac                      | e, and due to the ca                   | use(s) and manner as st             | ated.  |
|                | To the Hospitel or At<br>within 24 hours effer d<br>To the Funerel Direct<br>completely filled in by   | ledi              | one)  |   |                  |  |  |  |                                     |  |
|                | To To  | Σ                 | 29b. Signature and title of certifier   |   |                  | 29c. Licer                             | ise number                               | 29                                     | 9d. Date signed (Month, L           | Day, Year)                                   |
| ,              |  |                   | 1 (Oofra)   |   |                  | DO                                     | 25514                                    | 18                                     | 12/11/200                           | 05   |
| 1_             | (3)  |                   | 30. Name and address of person who co   | ompleted cause of death (Ite                                | т 23а) (Туре,    | Print)                                 |  |  |                                     |  |
|                |  |                   | DELROY ANGL:  | IN, 12201 Plu   | m Orch           | nard Dri                               | ve Silve                                 | rspring,                               | mg 209                              | 04   |
|                | Sta<br>Registi   |                   | 31. Date filed (Month, Day, Year)  DEC 1 6 2005   | ompleted cause of death (Ite                                | aturo            | W                                      |  | . / (                                  |                                     |  |

|            |  | . 1              | For State Registrar  | State of M   | aryland                            |                       | artment of H                              |                           | and Me                                |  | ene                      | 5  | +2234   |
|------------|--|------------------|--|--|------------------------------------|-----------------------|---|---------------------------|---------------------------------------|--|--------------------------|--|---|
|            | Physicia   | ın               | 1. Decedent's Name (First, Middle, L   | ast)   | Boca                               | cip                   |   |                           |                                       | 2. Date of Death<br>Month<br>/ Z             | Dav                      | Year 005   | 3. Time of Death  0700 M                      |
|            | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, ga  | ive street and number,   | )                                  |                       | 4b. City, Town, or                        |                           | of Death                              |  | 4c. County               |  |   |
| . 1        |  |                  | Anne Arundel Me  |  |                                    |                       | Annapo                                    |                           |                                       |  | An                       |  | rundel  |
|            | Funeral<br>Director  |                  | 5. Social Security Number 6. 046-14-4848   | Sex 7. As<br>1 XM 2 ☐ F  | ge (In yrs. la<br>80               | ast birthday)<br>Yrs. | If Under 1 Year<br>Months Days            | If Under                  | Min.                                  | 8. Date of Birth<br>(Month, Day,<br>Oct. 16; | Year)<br>1925            |  | lace (State or Foreign<br>try)<br>necticut    |
|            | D<br>D   | -                | Usual Residence of Decedent  |  | 10a Cib                            | . Town or Lo          | ention                                    |                           |                                       |  |                          | 1  | 0d. Inside City Limits                        |
|            | arylar<br>show   | .                | 10a. State 10b. County   | 1 1  | 1                                  |                       |   |                           |                                       |  |                          |  | 1 ☐ Yes 2√ No                                 |
|            | he Mi  | ecto             | MD Anne A  | runde1   |                                    | Church                | 10f. Zip Code                             |                           |                                       | 10   | Og. Citizen of V         | What Coun  |   |
|            | a or 2   | ā                | 1238 Delaware A  | Weniie   |                                    |                       |   | 733                       |                                       |  | USA                      |  | ,   |
|            | eath   | Funeral Director | 11. Marital Status   | 12. Was Deceden  | t Ever in U.:                      | S. 13.                | Was Decedent of H                         |                           | gin? (Spec                            | cify Yes or No-                              | 14. Rac                  | e - Americ   |   |
| 36         | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel; or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be nutitled at  | by Fun           | 1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced   | Armed Forces  1 XYes 2 If Yes, Give Year or Dates:                   | No                                 |                       | If Yes, specify Cuba<br>1 ☐ Yes 2 🏋 No    | an, Mexicar<br>Specify:   |                                       | Rican, etc.)                                 |                          | ck, White, i<br>v: Whi                                   |   |
| 21215-0036 | ture<br>sture  |                  | 15. Decedent's   | Education  | 17-13                              | 16a Dece              | dent's Usual Occup                        | ation                     |                                       |  | 16b. Kind of B           | usiness/Ind  | dustry  |
| 215        | 7, nin 7, nin 7, nin 7, nin 7, nin 1, | Completed        | (Specify only highest g<br>Elementary/Secondary (0-12)   | completed) Coltege (1-4or  | 5+)                                | life.                 | kind of work done of DO NOT use retired   | during mos<br>d)          | t or workin                           | lg   |                          |  |   |
| 212        | giene<br>grene<br>er the   | E O              | Ziottioinal yi oboditali y (o to)  | 2  |                                    | Indus                 | trial Spe                                 |                           |                                       |  | Dept. o                  |  | ny  |
|            | ould be filed within I Mental Hygiene. Arked other than hatic event, the M   | Be (             | 17. Father's Name (First, Middle, La   | st)  |                                    |                       |   |                           |                                       | (First, Middle, A                            | Maiden Surnan            | ne)  |   |
| Maryland   | should bind Ment<br>amarked<br>umatic  | 2                | Frank Boccia   |  |                                    |                       |   |                           |                                       | Casella                                      | 0: T                     | Otto Tie   | 0-4-1   |
| Jar        | 2 sho<br>and )<br>is me  | 1                | 19a. Informant's Name/Relationship   | 00e51 N2890  |                                    |                       | ng Address (Street                        |                           |                                       |  |                          |  |   |
|            | 1 and 2<br>Health<br>Iom 27 i  |                  | Mary D. Boccia 20a Method of Disposition   | (Wife)   | 20b. P                             | tace of Dispo         | Delaware                                  | 1                         |                                       |  | 20c. Location            |  |   |
| Ö          | if its   |                  | 1 ☐ Burial 2 XCremation 3  |  | B C                                | emetery, cre          | matory or other plac<br>ematory           |                           | 2-14                                  |  | Baltimo                  | •  |   |
| Baltimore, | permit. Pa<br>Departmer<br>Important<br>any injury   |                  | 4 □Donation 5 □ Other (Special Service Lice  |  | riet                               |                       |   | 1                         |                                       |  |                          | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,                  | Ш   |
| Ba         | permit. Pages 1 an<br>Department of Heal<br>Important: If Item 2<br>any injury or other<br>once.   |                  | Port 1   | 111  |                                    |                       | 2. Name and Addre<br>Hardesty<br>12 Ridge |                           |                                       |  |                          | m 214  | 401   |
| €. %       | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)          |  | et 195                             | TATI                  | ter the mode of dyir                      |                           |                                       |  |                          | o <sub>R</sub>   | Approximate Interval Between Onset and Death  |
| 1760,      | eath certificate be executed attending physician and for use as the burial-transit   | icai Examiner    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or a  |                                    |                       |   |                           |                                       |  |                          |  |   |
| .O. Box 68 | O O  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcom<br>1 ☐ Live birth<br>4 ☐ Pregnant<br>9 ☐ Unknown | 2 ☐ Feta<br>at time of d           | Ideath 3              | □Ectopic pregnanc                         | у                         | - PS-III                              |  |                          | ate of deliver   | ery<br>Day Year                               |
| Δ.         | w requires that the state of th | ρ                | Part II. Other significant condition   | s contributing to death  | but not res                        | ulting in the         | underlying cause gr                       | ven in Part               | · · · · · · · · · · · · · · · · · · · |  | bacco use con<br>es 2□No | 3 Prot   | he cause of death?<br>cably 4 ⊟Unknown        |
| Records,   | has<br>has   | Completed        |  |  |                                    |                       |   |                           |                                       | 24a. Was a<br>autops<br>perform<br>1 Yes     | SV                       | Were auto<br>prior to co<br>death?<br>1 \( \text{Yes} \) | opsy findings available impletion of cause of |
| Vital      | sician: Th<br>certilicete<br>rector, pag   | Be C             | 25. Was case referred to medical examiner?   |  |                                    |                       |   |                           | e of Death                            | Check only on                                | 10)                      |  |   |
| of V       | Physician:<br>this certific<br>ral director,   | မ                | 1 Yes 2 No   | Hospital: 1 Inpa   |                                    | ER/Outpatie           | IN SU DOA                                 |                           |                                       | ne 5 Reside                                  |                          |  | (y)   |
| n o        | ding P   | 5                | 27. Manner of Death 1 X Natural 5 ☐ Pending  | 28a. Date of In<br>(Month, L   | njury<br>Da <i>y</i> Yea <i>r)</i> | 28b. Time<br>Injury   | Wo  | iryat<br>ork?<br>]Yes 2.[ |                                       | 28d. Describe h                              | ow injury occu           | rrea   |   |
| Division   | Attendar death   | Certification:   | 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin  | t be 28e. Place of   | Injury - At h                      | ome, farm, s<br>by)   | treet, factory, office                    |                           |                                       | 28f. Location (S.<br>City or Town            |                          | ber or Run   | al Route Number,                              |
|            | To the Hospital or within 24 hours affe To the Funerel Dir. completely filled in I   | Cer              | 29a, Certifier 1 D Certifying  | Physician: To the be   | st of my kno                       | owledge, dea          | th occurred at the ti                     | ime, date a               | nd place, a                           | and due to the c                             | ause(s) and m            | anner as s   | stated.                                       |
|            | he Hos<br>in 24 h<br>he Fur<br>pletely   | Medical          | one)   | xeminer: On the basis<br>and manner                                  | of examina stated.                 | ation and/or i        |   |                           | ath occurr                            |  |                          | , ,  |   |
|            | To the within 2  | Σ                | 29b. Signature and title of certifier  | Themfer  | 11                                 | סרא                   | 1   | se number                 | 58                                    | 2  | 29d. Date sign           | ed (Month,   | 2005  |
| _          |  |                  | 30. Name and address of person w   | eINFFL   | D                                  |                       | SHADY                                     | 51                        | 5HD.<br>De                            | 0/15/  | De 2                     | RD<br>07   | 64.   |
|            | St<br>Regist   | ate<br>rar       | 31. Date filed (Mo/fith, Day, Year) DEC 14   | 2005   | strar's Signa                      | ature                 | A. R.                                     | 714 <sup>9</sup> 45       |                                       |  |                          |  |   |

|  |                                  | 1 - For State Registrar   | State of Maryla   |                         | artment of F  |   | -   | 7000                                     |                           | 2235   |
|--|----------------------------------|---|---|-------------------------|---|---|---|--|---------------------------|--|
| Phys   |                                  | Decedent's Name (First, Middle, Last)     LILLIAN S. BAYNA                                    | RD  |                         |   |   | 2. Date of De<br>Month<br>Dec   | _  | 0 0 5 °                   | 3. Time of Death 10:25 P                                       |
| Exan   |                                  | 4a. Facility Name (If not institution, give s<br>Genesis HealthC                              | treet and number) are - The   |                         | Eas   | r Location of Death<br>Ston                             |   | 4c. County                               | of Death                  | ot   |
| Funer<br>Directo   |                                  | 5. Social Security Number  214-34-8234  Usual Residence of Decedent                           | м <b>Ж</b> F 91   | Yrs.                    | If Under 1 Year Months Days                                   | Hours Min.  | JUNE th, 10   | y, <sup>Ye</sup> 1914                    | 9. Birthp                 | place (State or Foreigntry)                                    |
| Maryland     a-f show  | ctor                             | 10a. State 10b. County  MD TALBOT   | 10c. C  | EAS                     |   |   |   |  | 1                         | 10d. Inside City Limit   |
| after death with the M<br>or items 23a or 28a-f  | Funeral Director                 | 10e. Street and Number 207 WYE AVE.   |   |                         | 10f. Zip Code <b>2160</b>                                     | 1   |   | 10g. Citizen of                          | What Cour                 | ntry?  |
| If and 2 should be filed within 72 hours after death with the Maryland Fleatin and Mental Hygiene.  The fleatin and Mental Hygiene.  The fleating is marked other than "natural", or items 23a or 28a-f show other traumatic event. The Madical Example or Interest.                       | by                               | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced                            | 2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ANo If Yes, Give Year or Dates:   |                         | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 🗶 No    | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | pecify Yes or No<br>o Rican, etc.)  | Bla                                      | ce - Americ<br>ck, White, |  |
| ithin 72 hours<br>18.<br>18n "natural",  | Completed                        | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)             |   | (Give                   | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of worl                                     | king  | 16b. Kind of B                           | usiness/In                | dustry   |
| 2 should be filed within and Mental Hygiene. Is marked other than " aumatic event. Inc Ms.   | To Be Con                        | 12 17. Father's Name (First, Middle, Last)  MAX CHRISTOPHER SH                                | ERMAN   | Н                       | DMEMAKER  | 18. Mother's Nam  |   |  | HOMI                      | ξ  |
| 1 and 2 shou<br>Health and M<br>em 27 is mar   | -                                | 19a. Informant's Name/Relationship (Type JOANNE BAYNARD/DA                                    |   |                         | mg Address (Street WYE AVE.                                   | and Number or Ru  | ral Route Numbe   |  | State, Zip                | Code)  |
| icate be executed Wedject Physician and physician and sthe burial-transit  | edicai Examiner                  | 230. Was decedent pregnant  | Due to (or as a conse   | quence of): quence of): | er the mode of dyin   | RISON ST.   | ., EASTO  | ON, MD 2 rrest,                          | 1601                      | Approximate Interval Between Onset and Death                   |
| signed by the attendin   | Physician/M                      | in the past 12 months? 1 □ Yes 25 □ No 9 □ Unknown  Part II. Other significant conditions con | 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown  | death 5                 | JEctopic pregnancy  Other (specify)                           |   | 23e. Did to   | Mo                                       | nth                       | Day Year   |
| e law requires<br>has been signi   | Completed by                     |   |   |                         |   |   | 1 ☐ \<br>24a. Was<br>autop  | Yes 2 □ No<br>an 24b.                    | 3 Prob                    | -/   |
| To the Hospital or Attending Physician: The law requires that the death certifully 24 hours after the death certifully for the Functal Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a | Medical Certification: To Be Com | 27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier                | 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At I building, etc. (Specials: To the best of my kner: On the basis of examinand manner stated. | ify)                    | 28c. Injun World 1 Deet, factory, office                      | y at k? Yes 2 □ No                                      | perform the (Check only of orms 5 - Residue) Residue 28d. Describe to 28f. Location (Softy or Towns and due to the red at the time, | No No No No No No No No No No No No No N | er (Specify red           | 2 No  No  No  Route Number,  lated. 0 the cause(s)  Day, Year) |
| (5)  |                                  | 30. Name and address of person who con  |   |                         | Print) UTCHMA   | in's Lan  | ue E  | ASTON                                    | ME                        | 21601  |

Registrar

|            |  |                | 1 - For<br>State<br>Registrar   | State of  | Marylar  |  | artmen<br>rtificat     |  |              | and M                  | lental Hy                       | giene  | )5  | 42236  |
|------------|--|----------------|---|---|--|--|------------------------|--|--------------|------------------------|---------------------------------|--|---|--|
|            | Physici<br>/Medic  | al             | Decedent's Name (First, Middle, I  Jerry Newton BAI      4a. Facility Name (If not institution, c   | KER Sr.   | er)  |  | 4b City                | Town or                                | Location o   | of Death               | 2. Date of D<br>Month<br>Decemb | er 18  | Year 2005 nty of Death                              | 3. Time of Death                                   |
|            | Examin<br>Funeral  | ier            | 11128 Lakeview I  | Orive<br>Sex 7.   |  | last birthday)                         | Hag                    | erst<br>1 Year<br>Days                 |              |                        | 8. Date of B                    | Wash   | ningto  |  |
|            | Director   |                | 213-24-8609 Usual Residence of Decedent  10a, State 10b, County   | 1 <b>∑</b> M 2□F  | 74   | Yrs.                                   |                        | Days                                   | Hours        | Willi.                 | June                            | 28 1931  | Ma  | ryland   |
|            | death with the Maryland<br>ms 23a or 28e-f show  | Director       | Maryland Washing  | gton  |  | gersto                                 |                        | Code                                   |              |                        |                                 | 10g. Citizen                                   |   | 10d. Inside City Limits 1 ☐ Yes 2∑ No ntry?        |
| 215-0036   | J within 72 hours after death with the Marylan<br>riban .<br>I han "netural", or liems 23a or 28e-1 show<br>It's Madical Endminer rual by ridillish at | by Funeral     | 11128 Lakeview DT 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decede<br>Armed Force<br>1 □ Yes 24<br>If Yes, Give<br>Year or Date | es?<br>□No   |  | 1 🗆 Yes                | dent of Hi<br>cify Cuba<br>21 No       | Specify:     | gin? (Spi<br>n, Puerto | ecify Yes or N<br>Rican, etc.)  | Spe  | W   | etc.<br>nite                                       |
| -61717     | d within 72<br>giene.<br>er than "net  | Completed      | 15. Decedent's (Specify only highest to Elementary/Secondary (0-12)   |   | or 5+)   | life.                                  | kind of wo<br>DO NOT u | rk done d<br>se retired                | lurina most  |                        | ing                             |  | Business/Ir   | rnment   |
| yland      | 2 should be filed<br>and Mental Hygi<br>is marked other<br>reumatic event, II  | Be             | 17. Father's Name (First, Middle, La<br>Roy Sherman Baket   |   |  |  |                        |  | Cor          | a Ma                   | y Patt                          |  | ŕ   |  |
| re, mar    | 1 and<br>Health<br>sm 27<br>ther ti  |                | 19a. Informant's Name/Relationship  Dorothy M. Baker  20a. Method of Disposition  |   | 20b. F   | D.                                     | 3 Lak                  | evie                                   | w Dri        | ve,                    |                                 | town N   | lary1a  | nd 21740   |
| Baitimore, | permit. Pages<br>Department of i<br>Importent: If its<br>any Injury or o<br>once.  |                | 1 ☑ Burial 2 ☐ Cremation 3  '4 ☐ Donation 5 ☐ Other (Spe  21. Signature of Funeral Service Lice  Truck  | cify)<br>ensee  | 110  | untain<br>22                           | View<br>2. Name ar     | Cem                                    | s of Facilit | 111                    | nnich                           | Sharpsh<br>Funeral<br>rstown,                  | Home  | Maryland   |
|            | Physician<br>/Medical<br>Examiner  | er             | 23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate | a   | sed the death line.  **A O N   as a consect as a consect | th. Do not ent                         | er the mod             | le of dying                            |              | cardiac o              |                                 |  |   | Approximate<br>Interval Batween<br>Onset and Death |
| , na/sc    | death certificate be executed<br>e attending physician and<br>d for use as the burial-transit  | dical Examin   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decase or might that initiated events resulting in death) Last  | с   | as a consec  |  |                        |  |              |                        |                                 |  |   |  |
| O. Box     | the<br>y th  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No   | 23c. If yes, outco<br>1 □ Live birtl<br>4 □ Pregnan<br>9 □ Unknow           | at time of c   | Ideath 3                               | Ectopic po             |  |              |                        |                                 |  | Date of deliv<br>Month                              | ery<br>Day Year                                    |
| cords, r   | requires<br>een sign   | by             | Part II. Other significant conditions   | s contributing to deat  | h but not res  | sulting in the u                       | nderlying o            | ause give                              | S \$20       | 1100                   |                                 | tobacco use co                                 |   | he cause of death?                                 |
| vital Rec  | The la<br>ate has<br>page 2  | e Completed    | 25. Was case referred to medical  |   |  |  |                        |  | OC Plane     |                        | 1□ Yes                          | ormed?<br>2 No                                 | b. Were auto<br>prior to co<br>death?<br>1 \sum Yes | psy findings available impletion of cause of       |
| o          | ling Phys<br><br>After this<br>funeral dii   | To B           | examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigal  |   |  | ER/Outpatien<br>28b. Time of<br>Injury |                        | 8c. Injury<br>Work                     | at □ Nu      | rsing Ho               |                                 | idence 6 (1)                                   |   | (y)  |
| DIVISION   | or Dir   | Certification: | 3 Suicide 6 Could not determine   | ed 289. Place of building   | , etc. (Specii   |  |                        |  |              |                        | City or To                      | wn, State)                                     |   | il Route Number,                                   |
|            | To the Hospitel within 24 hours a To the Funerel I completely filled   | Medical        | 29a. Certifier (Check only one)  2 Medicel Ex   | Physician: To the be<br>eminer: On the basi<br>and manner                   | s of examina   | owledge, death<br>ation and/or in      | vestigation            | at the tim<br>, in my op<br>c. License | pinion, deat | d place, a             | and due to the                  | cause(s) and<br>date and plac<br>29d. Date sig | e, and due to                                       | o the cause(s)                                     |
|            | F 3 F 8  |                | 30. Name and address of person wh   | on completed sauce  | of death /lice   | n 23e) /T                              | D                      |  | 0/0          | 40                     |                                 | 12-19  | ,   |  |
| H-         | -/O<br>Sta<br>Registr  |                | BPPAY COHO  |   |  |  | ,                      | ADE                                    | 4570         | WN                     | ne D                            | 2/7  | YU  |  |

UNK 05-08360 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD State of Maryland / Department of Health and Mental Hygiene Rag. No. 005 Jonathan Barnes 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) DECEMBER 11, 2005 **Physician** 6:00a. JONATHAN RAY BARNES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON KEEDYSVILLE 22 MOUNTAIN ROAD | H Under 1 Year | H Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | AUG. 19, 1988 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MARYLAND 1∭M 2□F 217-29-5181 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than \*nature!', or Iteme 23a or 28a-f ehow eny injury or other traumatic event, if a Medical Examinar must be invitited at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MARYLAND

10e. Street and SHARPSBURG WASHINGTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21782 3818 MILLS ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC HIGH SCHOOL STUDENT 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CAROLE BERN ROBERT BARRETT ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21782 19a. Informant's Name/Relationship (Type, Print) 3818 MILLS ROAD, SHARPSBURG, MARYLAND CAROLE BARRETT, MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State SMITHSBURG CREMATORY 12/19/2005 SMITHSBURG, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature Furiera Service Ecensee 22. Name and Address of Facility 7606 OLD NATIONAL PIKE BAST FUNERAL HOME BOONSBORO, MARYLAND 23a. Part. Expertise disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Smoke and soot inhalation and thermal injuries Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien end detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? certificate hes been signed rector, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1)X Yes 2□No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of d ath?

es 2□ No 1 Yes 2 No Hospital or Attending Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐XYes 2 ☐ No After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation house fre 5:15 A M 1 ☐ Yes 2 X No after death. Dec 11, 2005 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 22 Mountain Roads Keedysville MD house 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Func completely fi (Check only one)

State

Tasha Z Greenbera 31. Date filed (Month, Day, Year) DEC 19 2005

29b. Signature and title of certifier

M.D. Registrar's Signature 1 Section

Freezer ND

30. Name and address of person who completed cause of Lath (Item 23a) (Type, Print)

111 PENN STREET BALTIMORE MARYLAND 21201 arts)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

DECEMBER 12, 2005

Registrar

|            |   |                     | 1 - For<br>State<br>Registrar   | State of                                    | f Marylar                               |                                 | artment o                           |                              |                                 | Mental Hy                              | giene<br>Reg: No.         | 05                            | 422                       | 38          |
|------------|---|---------------------|---|---|---|---------------------------------|-------------------------------------|------------------------------|---------------------------------|--|---------------------------|-------------------------------|---------------------------|-------------|
|            | Physici   | an                  | 1. Decedent's Name (First, Middle,  |   |   |                                 |                                     |                              |                                 | 2. Date of De<br>Month                 | ath<br>Day                | Year                          | 3. Time                   | of Death    |
|            | /Medic  |                     | Anna Louise Bea   |   |   |                                 |                                     |                              |                                 | Dec.                                   | 16                        | 2005                          | 1623                      | РМ          |
|            | Examin  | er                  | 4a. Facility Name (If not institution,<br>Homewood Nursi  | -   | nber)                                   |                                 | 4b. Cily, Tow                       |                              | ation of Death                  |  |                           | County of Dear                |                           |             |
|            | Funeral   |                     |   |   | 7. Age (In yrs.                         | last birthday)                  | If Under 1 Ye                       | _                            | Inder 24 Hrs.                   | 8. Date of Bir                         |                           | ashingt                       |                           | or Foreign  |
|            | Director  |                     | 218-34-3825 Usual Residence of Decedent   | 1□M <b>2</b> CxF                            | 98                                      | Yrs.                            | Months Da                           | ays Ho                       | ours Min.                       | 8. Date of Bir<br>(Month, Da<br>06/17/ | y, Year)<br>1907          | Co                            | thplace (State<br>buntry) | D           |
|            | how   |                     | 10a. State 10b. County  |   | 10c. Ci                                 | ty, Town or Lo                  | cation                              |                              |                                 |  |                           |                               | 10d. Inside               | 1           |
|            | 8a-f s  | cto                 | MD Washi  | ngton                                       |   | Hage                            | erstown                             |                              |                                 |  |                           |                               | 1 <u>X</u> Y∈             | s 2 No      |
|            | with the second   | Dire                | 10e. Street and Number<br>163 S. Prospec  | t Street                                    |   |                                 | 10f. Zip Cod                        |                              |                                 |  | 10g. Citiz                | en of What Co                 | ountry?                   |             |
|            | death<br>ms 23  | era                 | 11. Marital Status  | 12. Was Dece                                | dent Ever in U                          |                                 | Was Decedent                        | of Hispan                    | ic Origin? (Sp                  | ecify Yes or No                        |                           | 4. Race - Ame                 | nican Indian,             |             |
| 326        | be filed within 72 hours after death with the Maryland and Hygiene.  Id other then "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show event. The Medical Examiner russ be notified at | by Funeral Director | 1 ☐ Never Married 2 ☐ Marrie<br>3 ☑ Widowed 4 ☐ Divorced  | Armed Ford d 1 ☐ Yes If Yes, Giv Year or Da | 2 <b>[X</b> No<br>e                     |                                 | fYes, specify (<br>1 □ Yes 2 🙀      | Cuban, Me                    | exican, Puerto<br>ecity:        | Rican, etc.)                           |                           | Black, Whit<br>Specity: Wh    | e, etc.<br>nite           |             |
| 21215-0036 | 2 hou   | ted                 | 15. Decedent's  | Education                                   |   | 16a. Dece                       | dent's Usual Oc                     | cupation                     |                                 |  | 16b. Kin                  | d of Business/                | Industry                  |             |
| 215        | thin 7  | Completed           | (Specify only highest<br>Elementary/Secondary (0-12)  | College (1                                  | -4or 5+)                                | life.                           | kind of work do<br>DO NOT use re    | tired)                       | most of work                    | ing                                    |                           |                               |                           |             |
| 2          | led w<br>tygier<br>har th   | S                   | 12<br>17. Father's Name (First, Middle, La  |   |   |                                 | Teache:                             |                              | 14-M 4- 11                      | . 1000                                 |                           | ducation                      | on                        |             |
| lanc       | 0 = 0 =   | То Ве               | John Kieffer F  |   |   |                                 |                                     |                              |                                 | e (First, Middle,<br>unk) Wo           |                           | sumame)                       |                           |             |
| Maryland   | id 2 sho<br>Ith and N<br>27 Is ma<br>treuma   | •                   | 19a. Informant's Name/Relationshi<br>Elizabeth Joac   |   | ter                                     |                                 |                                     |                              |                                 | al Route Numb                          |                           |                               | Zip Code)                 |             |
| ā,         | s 1 an<br>í Heal<br>itam í  |                     | 20a. Method of Disposition  |   |   | Place of Dispo                  | sition (Name of                     | <del>-</del>                 |                                 | Date                                   |                           | ation - City or               | Town, State               |             |
| Ē          | Page<br>nent o<br>ant: If<br>ury or   |                     | 1  Burial 2  Cremation 3  Other (Spe  |   | siale                                   | -                               | L Cemet                             |                              | 12/21                           | ./2005                                 | Hage                      | rstown,                       | , MD 23                   | L740        |
| Baltimore, | permit. Pages 1 and 2 should by<br>Department of Heatils and Menta<br>Important: If itam 27 is marked<br>any injury or other treumatic e<br>906.  |                     | 21. Signature of Funeral Service Li   | College<br>Dence                            | 10                                      |                                 |                                     |                              |                                 | ald N.<br>eet, Ha                      |                           |                               |                           |             |
|            |   |                     | 23a. Part1. Efter the disease or c<br>shock, or heart failure. List of                                      | omplications that can't one cause on ex     | aused the deat                          |                                 |                                     |                              |                                 |  |                           |                               | Approxima<br>Interval Be  | ate         |
| i          | Physician   |                     | Immediate Cause (Final disease or condition   | ,   | Ina                                     |                                 | ولازه                               |                              |                                 |  |                           |                               | Onset and                 |             |
|            | /Medical<br>Examiner  |                     | resulting in death)   | Due to (                                    | or as a consec                          | juence of):                     |                                     | ·                            |                                 |  |                           |                               | -                         |             |
|            | pe sit  | iner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b   | or as a consec                          | juence of):                     |                                     |                              |                                 |  |                           |                               |                           |             |
| <b>.</b>   | certificate be executed ding physician and use as the burial-transit  | Examiner            | that initiated events<br>resulting in death) Last   | c<br>Due to (                               | or as a consec                          | uence of):                      |                                     |                              |                                 |  |                           |                               |                           |             |
| 8/60       | icate be<br>physicia<br>s the bur   | dicai               | l l   | d   |   |                                 |                                     |                              |                                 |  |                           |                               |                           |             |
| POX 6      | eath certific<br>attending p<br>for use as I  | ın/Me               | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outo                           | come of pregnanth 2 Feta                |                                 | Ectopic pregna                      |                              |                                 |  | 23                        | 3d. Date of deli              | very                      | <u> </u>    |
|            | 000   | Physician/Med       | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |   | ant at time of c                        |                                 | Other (specify                      |                              |                                 |  |                           | Month                         | Day                       | Year        |
| ds, r      | law requires that the<br>as been signed by th<br>2 should be detache  |                     | Part II. Other significant condition  | s contributing to de                        | ath but not res                         | ulting in the u                 | nderlying cause                     | given in F                   | Part I.                         | 23e. Did t                             |                           | e contribute to               | the cause of              |             |
| ecords,    | aw req<br>ts beer<br>2 shou   | Completed by        | Arterordero   | 15  |   |                                 |                                     |                              |                                 | 24a. Was                               | an                        | 24b. Were au                  | topsy findings            | s available |
| ř          | The<br>ate h  | Com                 | Apritic sten  | 0515  |   |                                 |                                     |                              |                                 |  | rmed?                     | death?                        | completion of<br>2 No     | cause of    |
| VITal      | Physician:<br>this certific<br>ral director,  | Be                  | 25. Was case referred to medical examiner?  | Hospital:                                   |   |                                 |                                     |                              | Place of Deat                   | h (Check only o                        | ne)                       |                               |                           |             |
| ō          | Phy<br>rat c  | 2                   | 1 ☐ Yes 2 No 27. Manner of Death  | 1 🗆 1                                       | npatient 2<br>If Injury<br>n, Day Year) | ER/Outpatien                    | t 3 DOA                             |                              | Nursing Ho                      | me 5 Resid                             |                           |                               | ify)                      |             |
| o<br>O     | Attending I<br>ir death.<br>actor: After<br>by the funer  | atior               | 1 Natural 5 ☐ Pending investiga   | tion  | i, Day Year)                            | Injury                          |                                     | njury at<br>Work?<br>I □ Yes | 2 🗆 No                          |  |                           |                               |                           |             |
| =          | al or Atter<br>after de<br>I Diracto<br>d in by th  | Certification:      | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | ad 286. Place                               | of Injury - At hig, etc. (Specif        | ome, farm, str                  | eet, factory, offi                  | ce                           |                                 | 28f. Location (5<br>City or Tov        | Street and i              | Number or Ru                  | ral Route Nui             | nber,       |
|            | To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | edicai C            | 29a. Certifier 1 Certifying (Check only one)  | Physician: To the caminer: On the ba        | sis of examina                          | wledge, death<br>tion and/or in | occurred at the<br>estigation, in m | e time, dai                  | te and place,<br>, death occurr | and due to the<br>red at the time,     | cause(s) ar<br>date and p | nd manner as<br>lace, and due | stated.<br>to the cause(  | s)          |
|            | To the within 2 To the complet  | Me                  | 29b. Signature and title of certifier   | 1   |   |                                 | ~                                   | ense num                     |                                 |  |                           | signed (Month                 | _                         |             |
|            |   |                     | <b>)</b> ////   | )/  |   |                                 | D                                   | 126                          | 801                             | 6                                      | 12,                       | 116/0                         | 5                         |             |
| hi         | 4-6   |                     | 30. Name and address of person w  | ompleted cause                              | of death (Iter                          | п 23а) (Туре,                   | Print)                              |                              |                                 |  |                           |                               |                           |             |
| IJ†        |   | 40                  | A. W. Ditto, MI 31. Date filed (Month, Day, Year)   | 747 No                                      | rthern                                  | Avenue                          | , Hager                             | stow                         | n, MD                           | 21740                                  |                           |                               |                           |             |
|            | Sta<br>Registr  |                     | DEC 19  | 2005  | ngistrar's Signa                        | 1. p.                           | ules                                |                              |                                 |  |                           |                               |                           |             |

|  |                | 1 - For<br>State<br>Registrar  | State of Marylar  | •                     | artment of F<br>rtificate of            |                           |                      | giene<br>Reg. No. 0 | )5                | 42240  |
|--|----------------|--|---|-----------------------|---|---------------------------|----------------------|---------------------|-------------------|--|
|  | U.E            | Decedent's Name (First, Middle, Last   | t)  |                       |   |                           | 2. Date of Dea       | ath                 |                   | 3. Time of Death                             |
|  | ician<br>dical | Gerald   | James   | Burd                  | sall                                    |                           | Decembe              | er 13,              | Year 2005         | 7:10 a M                                     |
|  | niner          | 4a. Facility Name (If not institution, give  | street and number)                                      |                       | 4b. City, Town, o                       | r Location of De          | ath                  |                     | nty of Death      |  |
|  |                | Calvert Memorial   | . Hospital  |                       |   | ce Frede                  |                      |                     | Calver            | t  |
| Funer  | al             | 5. Social Security Number 6. S   | 57 14 0 D E   |                       | Months Days                             | If Under 24 Hi            |                      | th<br>y, Year)      | 9. Birthp         | place (State or Foreign                      |
| Direct   | or             | 216-40-5057  | <sup>M 2   62</sup>                                     | Yrs.                  |   |                           | Jan 21               | , 1943              | Wasi              | n., D.C.                                     |
| and w  |                | Usual Residence of Decedent  10a. State 10b. County                                | 10c. C  | ity, Town or L        | ocation                                 |                           |                      |                     |                   | Od. Inside City Limits                       |
| Marylan<br>febow   | ō              | MD Calvert   | -   |                       | Owing                                   | as                        |                      |                     |                   | 1 ☐ Yes 2 💢 No                               |
| 28a  | Director       | 10e. Street and Number   |   |                       | 10f. Zip Code                           |                           |                      | 10g. Citizen o      | of What Cour      | ntry?  |
| 3 or   |                |  | Road  |                       | 2073                                    | 6                         |                      |                     | USA               |  |
| be filed within 72 hours after death with the Maryland tal Hyglene.  tal Hyglene.  of other than "netural", or items 23s or 28s-f show wit, I'm Marical Estrufragants to natilised at event, I'm Marical Estrufragants to natilised at   | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in U                              | J.S. 13.              | Was Decedent of F                       | Hispanic Origin?          | (Specify Yes or No   | - 14. R             | ace - Americ      |  |
| after or its   | T.             | 1 ☐ Never Married 2X Married   | Armed Forces? 1 ☐ Yes 2 XNo                             |                       | If Yes, specify Cub                     |                           | erto Hican, etc.)    |                     | lack, White,      | etc.   |
| hours af   | P              |  | If Yes, Give Year or Dates:                             |                       | 1 ☐ Yes 21 No                           | Specify:                  |                      | Spec                | wh                | nite   |
| within 72 hours after ene. than "natural", or Ite  | Completed      | 15. Decedent's Ed<br>(Specify only highest gra                                     | lucation<br>de completed)                               | (Give                 | dent's Usual Occup<br>kind of work done | during most of w          | vorking              | 16b. Kind of        | Business/In       | dustry                                       |
| Aithin Ne.   | la E           | Elementary/Secondary (0-12)  | College (1-4or 5+)                                      |                       | DO NOT use retire                       | *                         |                      |                     | 7 . 4             | -1   |
| fed w<br>tygie<br>her t  | වී             |  |   | seli                  | employed                                | 1                         | ame (First, Middle,  |                     |                   | cleaning                                     |
| d be fill to the out to even   | 8              |  | Burdsall  |                       |   |                           |                      | Maiden Sum          |                   | lson   |
| 2 should be filled within and Mental Hygiene. Is marked other than sumatic event, Iran Missumatic event.  | ٦              | Albert Oscar  19a. Informant's Name/Relationship (                                 |   | 19h Maili             | ina Address (Street                     | Lois                      | N. Rural Route Numbe | ar Cibrar Tou       |                   |  |
|  |                | Jean M. Burdsall   |   |                       | •                                       |                           | Owings,              |                     |                   | 0000   |
| S 1 and of Health Item 27 other tr   |                | 20a. Method of Disposition   | 20b.  | Place of Disp         | osition (Name of                        |                           | Date                 | 20c. Location       |                   | own, State                                   |
| Pages<br>nent of<br>int: If It   | 1              | 1 Burial 2 Cremation 3 C   | Hemovai from State                                      | •                     | matory or other pla                     | 1                         | 2/15/05              | _                   |                   |  |
| permit. Pages Depertment of Important: If Its  |                | 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen             |   |                       | 2. Name and Addre                       |                           | 2/15/05              | Alexan              | uria,             | VA   |
| Dep of   | ouce           | > W00. 3   | Su-   |                       | a - 2 55                                | 23.03                     | lome, P.A            | Carir               | nae M             | n 20736                                      |
|  | 81             | 23a. Part1. Enter the disease, or com-   | plications that caused the dea                          |                       |   |                           |                      |                     | iga, r.           | Approximate                                  |
| Phone  |                | shock, or heart failure. List only tmmediate Cause (Final                          | one cause on each line.                                 | 74 0 114              |   | 2 - 01                    |                      |                     |                   | Interval Between<br>Onset and Death          |
| Physicia<br>/Medic   |                | disease or condition resulting in death)   | Due to (or as a conse                                   | WWW COM               | y em                                    | goli                      |                      |                     |                   |  |
| Examin   | er             |  | Worbid  | Quence oi).           | - Pondes                                |                           |                      |                     |                   |  |
|  | e le           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a conse                                   | quence of):           | 7                                       |                           |                      |                     |                   |  |
| cuted<br>id<br>ansit   | Examine        | Cause (Disease or injury that initiated events                                     | . Diabet  | tes                   | mell                                    | iden                      |                      |                     |                   |  |
| icate be executed physicien and s the buriat-transit   | E              |  | Due to (or as a conse                                   | quence of):           | 1,0                                     |                           |                      |                     |                   |  |
| ate be e   | dical          |  | d tocal   | par                   | has 1                                   | JC1211                    | ves_                 |                     |                   | <u> </u>                                     |
| BOX 00 (00), death certificate be executed e attending physicien and of for use as the buriat-transle  | Ved            | IF FEMALE:   |   | <u> </u>              |   |                           |                      |                     |                   |  |
| leath certific attending p   | hvsiclan/Me    | 23b. Was decedent pregnant in the past 12 months?                                  | 23c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet | ancy<br>al death 3    | ⊒Ectopic pregnanc                       | y                         |                      |                     | Date of delive    | ,  |
| he death<br>the atte   | 20             | 1 Yes 2 No   | 4☐Pregnant at time of<br>9☐Unknown                      | death 5               | Other (specify)                         |                           |                      |                     | Month             | Day Year                                     |
|  | 9              |  |   |                       |   |                           | 00- D-1              |                     |                   |  |
| n & 58   | ه ا            | rait ii. Other significant conditions of   | ontributing to death but not re                         | suiting in the t      | anderlying cause gr                     | ven in Part I.            | 1 🗆 `                | ./                  |                   | he cause of death?                           |
| w require been si  | Completed      |  |   |                       |   |                           | -                    |                     |                   |  |
| N to to  |                | -  |   |                       |   |                           | 24a. Was<br>autor    | an 24t              | prior to co       | ppsy findings available mpletion of cause of |
| The The cete his page  | S              |  |   |                       |   |                           | 1 ☐ Yes              | rmed?<br>No         | death?<br>1 ☐ Yes | 2 🗆 No                                       |
| OI VILGI F Physician: Th rithis certificete ral director, pag  | B G            | examiner?  | Heavitali   |                       | i nu                                    |                           | eath Check only o    | one)                |                   |  |
| this aldin   |                |  |   | ER/Outpatie           | III 3 DDA                               |                           | Home 5 ☐ Resid       |                     |                   | (y)  |
| - b 56   | 0              | 27. Manner Death Natural 5 Pending   | 28a. Date of Injury<br>(Month, Day Year)                | 28b. Time o<br>Injury | Wo                                      | ryat<br>rk?<br>]Yes 2.⊟No | 28d. Describe I      | now injury occ      | urrea             |  |
| LIVISION  or Attending after death.  Director: After   | Cat            | 2 Accident investigation 3 Suicide 6 Could not b                                   |   | nome farm st          |   |                           | 28f Location (       | Street and Nu       | mhar or Pur       | al Route Number,                             |
| UIVISION  of or Attendir  safter death.  I Director: Al  | Certification: | 4 Homicide determined  | 28e. Place of Injury - At l<br>building, etc. (Spec     | ify)                  | reet, ractory, onice                    |                           | City or Tov          | vn, State)          | IIDer or Aura     | i Houte Number,                              |
| To the Hospitel or within 24 hours after To the Funerel Director completely filled in E  | 0              |  | ysician: To the best of my kr                           | lowledge dea          | th occurred at the fi                   | me, date and nia          | ice, and due to the  | cause(s) and        | manner as o       | tated  |
| 24 h<br>24 h<br>Fur<br>etely   | edical         | (Check only 2 Medical Exar   | niner: On the basis of examin<br>and manner stated.     | ation and/or in       | nvestigation, in my                     | opinion, death oc         | curred at the time,  | date and plac       | e, and due to     | o the cause(s)                               |
| o th   | 2              | 29b. Signature and title of certifier  | $\cap$  |                       | 29c. Licens                             |                           |                      | 29d. Date sign      |                   |  |
| ,- ,- 0  |                | Mellin Im  | 1x mo   |                       | 1)0                                     | 0604                      | 75                   | 12/14               | 105               | -  |
| . =-4  |                | 30. Name and address of person who   |   | m 23a) (Type          | , Print)                                |                           |                      | ~ ( (               | 104               |  |
| $I_{i,j}$  |                | TEREZA BUSH  |   | HOSP                  | ITAL 1                                  | 20AD.                     | PRINCE               | TRE                 | DERI              | CK MD206                                     |
| Control of the second  | State          | 31. Date filed (Month, Day, Year)  | 32. Registra Sigr                                       |                       | 1.0                                     | -                         |                      |                     |                   |  |
| Control of the contro | istrar         | DEC 1  | 5 2005 Range  | - H                   | Mark!                                   | 6                         |                      |                     |                   |  |

|              |   |                  | 1 - For<br>State<br>Registrar   | State of Ma                                     | ryland                 |                              | artmen<br>rtificat         |                         |                           | and M                   |   | giene                 | nn5                      | 42                                    | 241                      |
|--------------|---|------------------|---|---|------------------------|------------------------------|----------------------------|-------------------------|---------------------------|-------------------------|---|-----------------------|--------------------------|---------------------------------------|--------------------------|
|              | Division  |                  | 1. Decedent's Name (First, Middle, Last)  | )   |                        |                              |                            |                         |                           |                         | 2. Date of Dea<br>Month                   | ath<br>Day            | Va                       |                                       | e of Death               |
|              | Physici<br>/Medio   |                  | Vivian Beatri   | ce Bouch  | ard                    |                              |                            |                         |                           |                         | Decemb                                    |                       |                          |                                       | 00 p <sup>M</sup>        |
|              | Examir  | er               | 4a. Facility Name (If not institution, give   |   |                        |                              |                            |                         | Location o                | of Death                |   | 4c.                   | County of D              |                                       |                          |
|              |   |                  | Asbury Solomons   |   |                        |                              | If Under                   |                         | mons                      | Od Hen                  |   |                       | Calve                    |                                       |                          |
|              | Funeral Director  |                  | 5. Social Security Number 6. Sec. 1243–36–8459  | ]M 2427F  | (In yrs. Ia            | ast birthday)<br>Yrs.        | Months                     | Days                    | Hours                     | Min.                    | 8. Date of Birth<br>(Month, Day<br>Mar 3, | h<br>v. Year)<br>1001 | 9.1                      | Birthplace (Sta<br>Country)<br>Virgin | e or Foreign             |
|              |   |                  | Usual Residence of Decedent   | 82  |                        |                              |                            |                         |                           |                         | Mai J,                                    | 192                   | J                        | viigii                                | IIa                      |
|              | ylanc<br>how  |                  | 10a. State 10b. County  |   | 10c. City              | , Town or Lo                 | cation                     |                         |                           |                         |   |                       |                          | 10d. Inside                           | City Limits              |
|              | e Wa  | cto              | MD Calve  | rt  | So1                    | Lomons                       |                            |                         |                           |                         |   |                       |                          | 1 🗆 Y                                 | es 2 No                  |
|              | 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다 다   | Funeral Director | 10e. Street and Number  |   |                        |                              | 10f. Zip                   | Code                    |                           |                         |   | 10g. Citi             | zen of What              |                                       |                          |
|              | ath w   | rai              | 11450 Asbury Ci   |   |                        |                              |                            |                         | 688                       |                         |   |                       | USA                      |                                       |                          |
|              | er de<br>itam   | nue              |   | 12. Was Decedent E<br>Armed Forces?             |                        | 3. 13. \                     | Was Deced<br>f Yes, spec   | dent of Hi<br>cify Cuba | spanic Orig<br>n, Mexican | gin? (Spe<br>, Puerto l | cify Yes or No-<br>Rican, etc.)           |                       | 14. Race - A<br>Black, W | merican Indian<br>'hite, etc.         | •                        |
| 36           | irs aff   | by               | 1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced  | 1 ∰ Yes 2 ☐ N<br>If Yes, Give<br>Year or Dates: | O                      |                              | Yes                        | 2□ No                   | Specify:                  |                         |   |                       | Specify:                 | White                                 |                          |
| 21215-0036   | 72 hours after death with the Maryland<br>natural; or items 23a or 28e-f show<br>disal Examiner must be notified at   |                  | 15. Decedent's Edu  | cation  |                        | 16a. Deced                   | dent's Usua                | al Occupa               | ation                     |                         |   | 16b. Kii              | nd of Busine             | ss/industry                           |                          |
| 2            | b.<br>Bu "n<br>Med  | pie              | (Specify only highest grade<br>Elementary/Secondary (0-12)  |   | +)                     | (Give<br>life. L             | kind of wo.<br>DO NOT us   | rk done d<br>se retired | luring most<br>)          | t of workii             | ng  |                       |                          |                                       |                          |
| 7            | ed wil  | Completed        | ,   | College (1-4or 5-                               | ,                      | Nurs                         | e Pra                      | ctit                    | ioner                     | •                       |   | Fe                    | ederal                   | Govern                                | ment_                    |
| nd           | be fifted Hy d outh   | Be               | 17. Father's Name (First, Middle, Last)   |   | _                      |                              |                            |                         |                           |                         | (First, Middle,                           | Maiden                |                          |                                       |                          |
| Zla          | Men<br>Marke<br>Marke   | 2                | Benjamin  |   | 2                      | Salyer                       |                            |                         |                           | ırma                    |   |                       |                          | ngus                                  |                          |
| Maryland     | d 2 st<br>th and<br>7 is n<br>traum   | 1 8              | 19a. Informant's Name/Relationship (Ty  |   | `                      |                              |                            |                         |                           |                         | Route Numbe                               |                       |                          |                                       | 20770                    |
|              | 1 and<br>Healt<br>arm 2<br>other  |                  | Catherine Ashby 20a. Method of Disposition  | (daugnter                                       |                        | ace of Dispo<br>metery, cren |                            |                         | Bea11                     |                         |   |                       |                          | oro, MD<br>or Town, State             |                          |
| no<br>I      | ages<br>ont of<br>tt: if it   |                  | 1 Donation 5 Other (Specify)  | Removal from State                              |                        | metery, cren<br>ingto        |                            |                         |                           |                         | åry 27<br>106                             |                       | -                        | Virgir                                |                          |
| Baltimore,   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If item 27 is marked other than "natural; or items 23a or 28e-f show any figury or other traumatic event, the Madical Examiner must be notified at ance. |                  | 21. Signature of Fun-rational Control (Specify)   | 6//   | 1111                   |                              |                            |                         |                           |                         | Funera                                    |                       |                          |                                       |                          |
| ñ            | Depa<br>Impo<br>any ir  |                  | Michaeldt.  | Lee   |                        |                              |                            |                         |                           |                         | nd Blvd                                   |                       |                          |                                       | 0736                     |
|              |   |                  | 23a. Part1. Enter the disease, or compli<br>shock, or heart failure. List only or                           | ications that caused                            | the death              |                              |                            |                         |                           |                         |   |                       | <u> </u>                 | Approxin                              | nate                     |
|              | Pnysician   |                  | Immediate Cause (Final disease or condition   | Chrem   | - 1                    | and o                        | cotic                      | 10                      | المدين                    | a                       |   |                       |                          | Onset ar                              | id Death                 |
|              | /Medical  |                  | resulting in death)   | Due to (or as a                                 |                        | ence of):                    | 7                          | en.                     |                           |                         |   |                       |                          |                                       |                          |
|              | Examiner  | L                | Sequentially list conditions,   | o   |                        |                              |                            |                         |                           |                         |   |                       |                          |                                       |                          |
|              | nsit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a                                 | raonaaqu               | enda of).                    |                            |                         |                           |                         |   |                       |                          |                                       |                          |
|              | xecul<br>and<br>al-trar   | xan              | that initiated events<br>resulting in death) Last   | Due to (or as a                                 | consequ                | ence of):                    |                            |                         |                           |                         |   | <u>.</u>              |                          |                                       |                          |
| 8760,        | death certificate be executed<br>e attending physicien and<br>of for use as the burial-transit  | iai              |   | 4   |                        |                              |                            |                         |                           |                         |   |                       |                          |                                       |                          |
| 9            | ificate<br>g phys<br>as the   | edicai           |   |   |                        |                              |                            |                         |                           |                         |   |                       |                          |                                       |                          |
| Вох          | death certifica<br>attending pt<br>d for use as t   | lan/M            | Zab. Was decedent pregnant  | 3c. If yes, outcome o                           |                        |                              | Tetopia pr                 |                         |                           |                         |   | 2                     | 3d. Date of              | delivery                              |                          |
|              | deat<br>eation  | sicia            | in the past 12 months?<br>1 ☐ Yes 2 No  | 4 Pregnant at 1                                 |                        |                              | ]Ectopic pr<br>] Other (sp |                         |                           |                         |   |                       | Month                    | Day                                   | Year                     |
| P.0          | at the de<br>t by the a<br>stached  | Physicia         | 9 Unknown   |   |                        |                              |                            |                         |                           |                         |   |                       |                          |                                       |                          |
| Ś            | requires that the<br>een signed by th<br>nould be detache   | by               | Part II. Other significant conditions con   | ntributing to death bu                          | t not resu             | lting in the ur              | nderlying c                | ause give               | en in Part I.             |                         |   |                       |                          | to the cause o                        |                          |
| 010          | v requir<br>been s<br>should  | eted             |   |   |                        |                              |                            |                         |                           |                         | 1 🗆 Y                                     | es 2,2                | \$No 3□                  | Probably 4                            | Unknown                  |
| Vital Record | as cs   | ompieted         |   |   |                        |                              |                            |                         |                           |                         | 24a. Was a<br>autops                      | sy                    | prior                    | autopsy finding<br>o completion o     | is available<br>cause of |
| <u>=</u>     | ician: The l<br>certificate ha<br>rector, page  | O                |   |   |                        |                              |                            |                         |                           |                         | perfor                                    |                       | death<br>1 🗆 Y           |                                       |                          |
| ΖĬ           | Physician:<br>this certific<br>ral director,  | o Be             | 25. Was case referred to medical examiner?  | lospital:                                       |                        |                              | -                          | Othe                    |                           |                         | (Check only or                            |                       |                          |                                       |                          |
| of           |   |                  | 1 ☐ Yes 2 € No  27. Manner of Death   | 1 ☐ Inpatier<br>28a. Date of Injur              |                        | R/Outpatien<br>28b. Time of  |                            | 8c. Injury              | 4 PAUI                    |                         | ne 5 Reside                               |                       |                          | pecify)                               |                          |
| on           | Attending I<br>r death.<br>ector: After<br>by the funer   | tio              | 1€Natural 5 Pending 2 Accident investigation  | (Month, Day                                     | Year)                  | Injury                       | М                          | Work                    | (?<br>Yes 2 □ N           |                         |   |                       | 00001100                 |                                       |                          |
| Division     | Attender death  | ertification;    | 3 Suicide 6 Could not be determined   | 28e. Place of Inju                              |                        |                              | eet, factory               | , office                |                           | 2                       | 8f. Location (S                           |                       |                          | Rural Route N                         | umber,                   |
| Ö            | pital or Al<br>ours after o<br>laral Direc<br>filled in by  | Cert             | 4   Hottiicide  | building, etc                                   | . (Specity)            | ,                            |                            |                         |                           |                         | City or Tow                               | n, State)             |                          |                                       |                          |
|              | Hospital or Atten<br>24 hours after deatl<br>Funaral Director:<br>tely filled in by the   | edical           | 29a. Certifier 12 Certifying Physical Check only 2 Medical Exami  | sician: To the best oner: On the basis of       | f my know<br>examinati | viedge, death                | occurred                   | at the tim              | e, date and               | d place, a              | nd due to the c                           | ause(s)               | and manner               | as stated.                            | 0/6/                     |
|              | To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medi             | Orie)   | and manner sta                                  | ed.                    |                              |                            |                         |                           |                         |   |                       |                          |                                       |                          |
|              | To To   |                  | 29b. Signature and title of certifier   | 1/10  |                        | A)                           |                            | :. License              |                           |                         |   |                       |                          | inth, Day, Year                       |                          |
|              |   |                  | 20 Novel  | 1 I male  | 150                    | 134                          |                            |                         |                           |                         | •   | / CF C                | - <del>-</del>           | 10,2                                  |                          |
|              | 1+08  |                  | 30. Name and address of person who co<br>David J. Tardio,   |   |                        |                              |                            | 1. #5                   | 310 I                     | Orine                   | e Frede                                   | ari ol                | <sub>₹</sub> 1MD         | 20678                                 |                          |
|              | Sta   | ite              | 31. Date filed (Month, Day, Year)   | 32. Registra                                    | S Signati              | nte<br>PAT CUT               | _ Iwal                     | . η .                   | 1 و∪حد                    |                         | ~ II GUE                                  | JE E()                | اللالا و دا              | 20010                                 |                          |
|              | Registi   |                  | DEC 1   | 4 2005  | Colum                  | , K                          | 100                        | Me                      |                           |                         |   |                       |                          |                                       |                          |

| •  | *  | ı                   | 1 - For<br>State<br>Registrar Amended ite  | State of Marylar   |  |  |                                |  |  | 42242  |
|--|--|---------------------|--|--|--|--|--------------------------------|--|--|--|
|  | Physici<br>/Medic<br>Examin  | cal                 | Decedent's Name (First, Middle, Last,     Clarence     Aa. Facility Name (If not institution, give   | Brown  | JR   | ity, Town, or Location   | 2                              | 2. Date of Death<br>Month Da               |  | 3. Time of Death                                 |
| i de la companya de l | Funeral<br>Director  | lei                 | Coastal Hospice At<br>5. Social Security Number 6. Sec<br>219-46-4646  | The Lake   | Sa   | der 1 Year   I Unde  | 1 D<br>or 24 Hrs. 8            | Date of Birth<br>(Month, Day, Year,        | Dicomi                                       |  |
|  | r the Maryland   | rector              | Usual Residence of Decedent  10a. State 10b. County  MD WCOM  10e. Street and Number   | 10c. Ci  | PITTSVI                                    | Zip Code   |                                | 10g. Ci                                    | itizen of What Co                            | 10d. Inside City Limits 1,                       |
| 36   | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28e-f show other traumatic event, the Madical Examiner must be notified at | by Funeral Director | 35080-OLD OLEA  11. Marital Status  17 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 Yes 25 No<br>If Yes, Give<br>Year or Dates:   | If Yes,                                    | 21852<br>accedent of Hispanic O<br>specify Cuban, Mexica<br>s 2 No Specify | rigin? (Speci<br>an, Puerto Ri | fy Yes or No-<br>can, etc.)                | USA  14. Race - Ame Black, White  Specify: R | erican Indian,                                   |
| 21215-0036   | filed within 72 hour<br>Hygiene.<br>Ather than "natural<br>ent, the Medical Ex   | Completed t         | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)  | cation   | life. DO NO                                | work done during mo<br>Tuse retired)                                       |                                | w  | Kind of Business                             | AND BERRY  |
| Maryland   | 2 should be fill and Mental Hy Is marked oth raumatic event  | To Be               | 17. Father's Name (First, Middle, Last)  ARENCE  19a. Informant's Name/Relationship (Ty  | pe, Print)   | and the same of                            | ess (Street and Numb   | BOT OF RURAL F                 | Route Number, City                         | TIMDRE<br>or Town, State,                    |  |
| Baltimore, I   | Page<br>nent o<br>ant: If<br>ury or  |                     | 20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)   | emoval from State  | Place of Disposition (cometery, crematory) | Name of or other place)  | 12/17                          | 105 WHI                                    | ocation - City or<br>ALEYUS C                | ΛΙ.  |
| ■ Bal  | permit. Pa<br>Departmen<br>Important<br>any Injury<br>once.  |                     | 21. Signature of Funeral Service Licens  23a. Part 1. Enter the disease, or compl  | Knird  | 917-0                                      | and Address of Faci  | AST                            | SAUSBURG<br>SAUSBURG                       |  | Approximate                                      |
| 4 8 47   | Physician<br>/Medical<br>Examiner  | ăi                  | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | Due to (or as a consec   | Encephe                                    | 1 11   |                                | oop.iu.o., uiios.,                         |  | Interval Between<br>Onset and Death              |
| 8760,  | rate be executed hysicien and the burial-transit   | icai Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  |  | •  |                                |  |  |  |
| P.O. Box 6   | ath certific<br>ttending p<br>for use as   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of c  | al death 3 ⊟Ectopio                        | c pregnancy<br>(specify)   |                                |  | 23d. Date of del<br>Month                    | ivery<br>Day Year                                |
|  | w requires that the de<br>been signed by the s<br>should be detached t   | <u>م</u>            | Part II. Other significant conditions cor  | ntributing to death but not res  | sulting in the underlyin                   | g cause given in Part  | 1.                             |  |  | o the cause of death?                            |
| Vital Records,   |  | e Completed         | 25. Was case referred to medical   |  |  |  |                                | 24a. Was an autopsy performed?             | prior to death?                              | utopsy findings available completion of cause of |
| Ž  | W 10   | To B                | examiner?  | ospital: 1 Appatient 2   | ER/Outpatient 3                            | Other  |                                | Check only 5ne) 5 ☐ Residence              | 6 □Other (Sne                                | cutul  |
| Division of  | ding<br>After<br>fune  | Certification: T    | 27. Manner of Death  Natural 5 Pending investigation 3 Suicide 6 Could not be  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury                     | 28c. Injury at<br>Work?<br>1 Yes 2   | 28c                            | d. Describe how inju                       | ry occurred                                  |  |
| Divi   | 10 th 00 cm  |                     | 4 Homicide determined  | 28e. Place of Injury - At h building, etc. (Special Sician: To the best of my known to the street of | fy)  |  |                                | Location (Street ar<br>City or Town, State | 9)   |  |
|  | To the Hospitel within 24 hours a To the Funerel Completely filled   | Medical             | (Check only one)  29b. Signature and title of certifier  | ner: On the basis of examina and manner stated.  | ation and/or investigat                    | ion, in my opinion, de<br>29c. License number                              | ath occurred                   | at the time, date and                      | d place, and due                             | to the cause(s)                                  |
|  | 1/3/<br>5 <u>3</u> 5 <u>0</u>  |                     | (will  | 2 un   |  | Α.   |                                |  | te signed (Monti<br>2 - / 4-                 |  |
| _  | 100  |                     | David E. Couca   | mpleted cause of death (Iter   | m 23a) (Type, Print)                       | in P.O.  | BOX                            | 1733 8                                     | Salish                                       | -05<br>MD21862                                   |
| 100  | Sta  | ite<br>ar           | 31. Date filed (Month, Day, Year)  | 32. Redistrar's Signa  | ature                                      | A.G.   | •                              |  |  | )  |

|            |   |                   | For<br>State<br>Registrar   | State of Marylan   |                                  | artment of Health  |  | lygiene<br>Reg. No. 0 0 5                           | 42243  |
|------------|---|-------------------|---|--|----------------------------------|--|--|---|--|
|            | - X - 餐!  | (%)               | 1. Decedent's Name (First, Middle, Last)  |  |                                  |  | 2. Date of<br>Month                                  | Death<br>Day Year                                   | 3. Time of Death                                 |
| н          | Physicia  |                   | Charles Bots  | sford  |                                  |  | 12   | 13 05   | 12: 10 AM  |
|            | /Medic<br>Examin  |                   | 4a. Facility Name (If not institution, give s   | treet and number)  |                                  | 4b. City, Town, or Location                              | on of Death  | 4c. County of Dea                                   |  |
| 1 36       |   | 100               | Coastal Hospice at  | the Lake   |                                  | Salsbury!  | bruland  | Wicomi  | 20   |
| 4          | Funeral   |                   | 5. Social Security Number 6. Sex  | 7. Age (In yrs.  | last birthday)                   |  | der 24 Hrs. 8. Date of (Month,                       | Birth 9. Bir<br>Day, Year) C                        | thplace (State or Foreign ountry)                |
|            | Director  |                   | 578-54 <b>-</b> 8965  | <sup>M 2□ F</sup> 64   | Yrs.                             | World Days Hob   | 7/19   |   | hington, DC                                      |
|            | P .   |                   | Usual Residence of Decedent   | 140. 00  |                                  |  |  |   |  |
|            | inylar<br>Show  | _                 | 10a. State 10b. County  |  | y, Town or Lo                    |  |  |   | 10d. Inside City Limits 1 Yes 2 No               |
|            | Ba-f.   | cto               | Maryland Worcest  | er o   | cean P                           |  |  | .,  |  |
|            | ith th  | Director          | 10e. Street and Number  |  |                                  | 10f. Zip Code  |  | 10g. Citizen of What C                              | ountry?  |
|            | 23a   | rai               | l Driftwood Lane  |  |                                  | 21811  |  | USA   |  |
|            | r de  | Funeral           | Tr. Warter Clares   | <ol><li>Was Decedent Ever in U.<br/>Armed Forces?</li></ol>                  | .S. 13.                          | Was Decedent of Hispanic<br>If Yes, specify Cuban, Mexi  | Origin? (Specify Yes or<br>can, Puerto Rican, etc.)  | No- 14. Race - Am<br>Black, Whi                     |  |
| 36         | or l  | by Fi             | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 █ <b>X</b> No<br>If Yes, Give<br>Year or Dates:                    |                                  | 1 ☐ Yes <b>X</b> ☐ No Spec                               | ify:   | Specify:  | white  |
| 21215-0036 | illed within 72 hours after death with the Maryland Hygiene. Hygiene. then "natural", or Items 23s or 28s-f show int, it a Medical Evarding must be notified at   | d b               | 15. Decedent's Educ   |  | 160 Dogg                         | dent's Usual Occupation                                  |  | 16b. Kind of Business                               |  |
| 5          | "nai  | Completed         | (Specify only highest grade   |  | (Give                            | kind of work done during π<br>DO NOT use retired)        | nost of working                                      | Tob. Kind of Business                               | Viridustry                                       |
| 12         | withii<br>ane.<br>then  | E C               | Elementary/Secondary (0-12)   | Cottege (1-4or 5+)   |                                  | k Auditor  |  | Banking   |  |
| 9          | Hygi<br>Hygi<br>ther<br>ont,  | ŏ                 | 17. Father's Name (First, Middle, Last)   | •  | 2011                             |  | ther's Name (First, Mide                             |   |  |
| an         | d be<br>antal   | To Be             | Frederick Botsford  | l  |                                  | Ma   | athilda Fre  | V   |  |
| Maryland   | 12 should be filed within h and Mental Hygiene. 7 is marked other then "fraumatic event, the Mer  | F                 | 19a. Informant's Name/Relationship (Type  |  | 19b. Maili                       | ng Address (Street and Nur                               |  | <b>^</b>  | Zip Code)  |
| M          | and 2 seath ar n 27 is nar trau   |                   | Annette Botsford/w  | ife  | 1 Dr                             | iftwood Lane   | Ocean Pine   | es, MD 21811  |  |
| ē,         | ーエッニ  |                   | 20a. Method of Disposition  | 20b. F   | Place of Dispo                   | osition (Name of   | Date   | 20c. Location - City of                             | Town, State                                      |
| 0          | Pages<br>nent of<br>int: if it  |                   | 1 ☐ Burial 2 【A Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State  |                                  | matory or other place) y Crematory                       | 12/14/05   | Salisbury   | , MD   |
| Baltimore, | permit. Pag<br>Department<br>Important: I<br>any injury c   |                   | 21. Signature of Funeral Service Ligense  |  |                                  |  | 1  |   |  |
| Ba         | permit. Departn Imports any inju  |                   | > Hell & Alex   | LADY (ESP  | ji j                             | Name and Address of Fa<br>Holloway Fund<br>501 Snow Hill | eral Home Pi<br>l Rd., Sali:                         | rofessional<br>sbury, MD 21                         | Association<br>804                               |
| 4          | - 3   |                   | 23a. Part1. Enter the disease, or compli-<br>shock, or heart failure. List only on                          | cations that caused the deat   |                                  |  |  |   | Approximate<br>Interval Between                  |
|            | Physician   |                   | Immediate Cause (Final  | Motesta  | Mark                             | bount M  | clarona  |   | Onset and Death                                  |
|            | /Medical  |                   | disease or condition<br>resulting in death)   | Due to (or as a conseq   | uence of):                       | The the  | COMONEL  |   | O. XIX   |
| 1          | Examiner  |                   |   |  |                                  |  |  |   |  |
|            |   | Jer               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq   | uence of):                       |  | -  |   |  |
|            | uted<br>id<br>ansit   | Examiner          | Cause (Disease or injury that initiated events  |  |                                  |  |  |   |  |
| o,         | exectan an arright  |                   | resulting in death) Last  | Due to (or as a conseq   | juence of):                      |  |  |   |  |
| 8760,      | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medical |   |  |                                  |  |  |   |  |
| 9          | tifica<br>ng ph<br>as th  | fed               | (FEGMALS)   |  |                                  |  |  |   |  |
| Box        | that the death certific<br>ed by the attending pl<br>detached for use as t  | an/N              | 23b. was decedent pregnant  | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta                     |                                  | Ectopic pregnancy  |  | 23d. Date of de                                     | •  |
|            | deal  | Sicia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐ Pregnant at time of d   |                                  | Other (specify)  |  | — Month   | Day Year   |
| P.0        | at the<br>by the  | , h               | 9 Unknown   |  |                                  |  |  |   |  |
|            | res tha<br>igned<br>be det  | by F              | Part II. Other significant conditions con   | tributing to death but not res   | ulting in the u                  | inderlying cause given in Pa                             | urt I. 23e. D  | id tobacco use contribute t                         | o the cause of death?                            |
| ord        | w require<br>been si<br>should t  | ed                |   |  |                                  |  | 1  | ☐ Yes 2DXNo 3☐ P                                    | robably 4 Unknown                                |
| Records,   | aw ri<br>as be<br>2 sh  | Completed         | 0   |  |                                  |  | 24a. W   |   | utopsy findings available completion of cause of |
| ď          | sician: The law<br>s certificate has t<br>irector, page 2 s   | E                 |   |  |                                  |  |  | erformed? death?                                    |  |
| Vital      | ian:<br>rtiffice<br>stor, i   | a                 | 25. Was case referred to medical  | 111  |                                  | 26. PI   | ace of Death Check on                                |   |  |
| of V       | Physician:<br>this certificanal director,   | To B              | examiner?   | ospital: 1 Impatient 2 🗆   | ER/Outpatie                      | nt 3 DOA Other: 4  | Nursing Home 5 R                                     | esidence 6 Other (Spe                               | ecify)   |
| 0          | ding Phys<br>n.<br>After this<br>funeral di   |                   | 27. Manner of Death Natural 5 ☐ Pending   | 28a. Late of Injury<br>(Month, Day Year)                                     | 28b. Time o                      | f 28c. Injury at Work?                                   | 28d. Descrit   | be how intury occurred                              |  |
| <u>0</u>   | Attending r death.  | atic              | 2 Accident investigation  |  |                                  | M 1 Yes 2  | □No  |   |  |
| Division   | or Atte   | Certification:    | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At he building, etc. (Specif                          | ome, farm, st                    | reet, factory, office                                    | 28f. Locatio<br>City or                              | n (Street and Number or F<br>Town, State)           | lural Route Number,                              |
|            | 0 = = =   | 4                 |   |  |                                  |  |  |   |  |
| _          | rs al   |                   |   |  |                                  |  |  |   |  |
| _          | Hospital of hours all funaral Dely filled i   |                   | (Check only 🖊 2 🔲 Medical Examin  | sician: To the best of my kno<br>ner: On the basis of examina                | owledge, deat<br>ation and/or in | h occurred at the time, date                             | and place, and due to t<br>death occurred at the tin | the cause(s) and manner and du                      | s stated.<br>e to the cause(s)                   |
| J          | the Hospital of hin 24 hours at the Funaral Dupletely filled i  | edical            | (Check only 2 Medical Examination)  | sician: To the best of my knoter: On the basis of examina and manner stated. | owledge, deat<br>ation and/or in | vestigation, in my opinion, o                            | death occurred at the tin                            | ne, date and place, and du                          | e to the cause(s)                                |
|            | To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director.  |                   | (Check only 🖊 2 🔲 Medical Examin  | ner: On the basis of examina   | owledge, deat<br>ation and/or in | 29c. License numb  | death occurred at the tin                            | ne, date and place, and du<br>29d. Date signed (Mon | e to the cause(s)                                |
| _          | To the Hospital of within 24 hours at To the Funaral D  | edical            | (Check only one)  2D Medical Examination one)  29b Signature and title of certifier                         | ner: On the basis of examina and manner stated.                              | ation and/or in                  | 29c. License numb  | death occurred at the tin                            | ne, date and place, and du<br>29d. Date signed (Mon | e to the cause(s)                                |
| _          | To the Hospital of within 24 hours at To the Funaral D  | edical            | (Check only 2 Medical Examination)  | ner: On the basis of examina and manner stated.                              | ation and/or in                  | 29c. License numb  | death occurred at the tin                            | ne, date and place, and du<br>29d. Date signed (Mon | e to the cause(s)                                |
|            | To the Hospital of within 24 hours at To the Funeral D Completely filled i  | Medical           | (Check only one)  2D Medical Examination one)  29b Signature and title of certifier                         | ner: On the basis of examina and manner stated.                              | n 23a) (Type,                    | 29c. License numb  | death occurred at the tin                            | ne, date and place, and du                          | e to the cause(s)                                |

CPM 05-08419 Belinda Brabston

Unpend Tues 7,20 1, per Mi, 331, 1/5/00 III. Ensure All Copies Are Legible.

| inda           | a Brabs   | sto                           |  | Inpend Ttem#2:                                 | State of                                | Marvlan   | <b>E,GSSI,</b><br>d / Depa | I/5/06<br>artmen                     | t of H          | ealth a       | ind M      | ental Hy                        | giene                   | )                         |                                     |                       |
|----------------|---|-------------------------------|--|--|---|---|----------------------------|--------------------------------------|-----------------|---------------|------------|---------------------------------|-------------------------|---------------------------|-------------------------------------|-----------------------|
|                |   | •                             | For<br>State<br>Registrar  |  |   |   |                            | rtificat                             |                 |               |            |                                 | Reg. No                 | 000                       | 422                                 | 14 14                 |
|                |   |                               |  | ne (First, Middle, Last)                       |   |   |                            |                                      |                 |               |            | 2. Date of De<br>Month          |                         | Y Agar                    | 3. Time of                          |                       |
|                | Physicia<br>/Medic  | al                            | Belinda  |  | rabsto                                  |   |                            |                                      |                 |               |            | Decembe                         |                         | 3, 2005                   | 10:00                               | ) A™                  |
|                | Examin  | er                            |  | (If not institution, give s<br>arwick Lane     |   | ber)  |                            |                                      |                 | Location o    |            |                                 | 40.                     | Somer                     |                                     |                       |
| >              | Funeral   |                               | 5. Social Security   | Number 6. Sex                                  | 7                                       | . Age (In yrs.                                  | last birthday)             |                                      |                 | If Under 2    |            | 8. Date of Bir<br>(Month, Da    | th<br>(v. Year)         | 9. Bii                    | thplace (State o                    | r Foreign             |
| 0              | Director  |                               | 213-60-  | 0021   | IM AND F                                | 53  | Yrs.                       | Months                               | Days            | Tiodis        |            | 01/01/1                         |                         |                           | ryland                              |                       |
| 3              | M   |                               | Usual Residence<br>10a. State  | of Decedent<br>10b. County                     |   | 10c. Cit  | y, Town or Lo              | ocation                              |                 |               |            |                                 |                         |                           | 10d. Inside Ci                      | ty Limits             |
|                | of eho  | tor                           | MD   | Somerset                                       |   | Pr  | incess                     | Anne                                 |                 |               |            |                                 |                         |                           | 1 Yes                               | 2 🗌 No                |
|                | or 28a  | lirec                         | 10e. Street and N  |  |   |   |                            | 10f. Zip                             |                 |               | -          |                                 | 10g. Cit                | izen of What C            | ountry?                             |                       |
|                | 23a c   | raiD                          | 11219  | Warwick Lar                                    |   |   | 0 10                       | 1                                    | 1853            | i i - Onio    | =:-2/5     | ait. Van as N                   |                         | USA<br>14. Race - Am      | erican Indian                       |                       |
|                | ttems<br>treet  | -une                          | 11. Marital Status   | rried 2 Married                                | 12. Was Deced<br>Armed Ford<br>1 Tyes   | ces?  | .5.                        |                                      |                 |               | , Puerto   | ecify Yes or No<br>Rican, etc.) |                         | Black, Wh                 |                                     |                       |
| 920            | urs ar  | by                            | _  | Divorced                                       | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Da | tes:  |                            | 1 🗌 Yes                              | 2 No            | Specify:      |            |                                 |                         | Specify: W                | hite                                |                       |
| 21215-0036     | within /2 nours atter deem with the maryland<br>ene.<br>Then "naturel", or tems 23s or 28s-f ehow<br>Te Madical Exemit ar mast be notified at   | Completed by Funeral Director | (Sp  | 15. Decedent's Edu<br>ecify only highest grade |   |   | (Give                      | dent's Usu<br>kind of wo<br>DO NOT u | rk done d       | during most   | t of worki | ng                              | 16b. K                  | ind of Business           | s/Industry                          |                       |
| 121            | within<br>then<br>then  | Jup                           | Elementary/Sec   | condary (0-12)                                 | College (1-<br>none                     | 4or 5+)   |                            | sable                                |                 | •/            |            |                                 |                         | none                      |                                     |                       |
| d 2            | other<br>other  | Be Co                         |  | e (First, Middle, Last)                        |   |   |                            |                                      |                 |               |            | (First, Middle                  |                         | -                         |                                     |                       |
| /lar           | Menta<br>Menta<br>arked<br>atic ev  | To E                          | Merritt  | Lewis Bul                                      | 1                                       |   |                            |                                      |                 |               |            | e Whit                          |                         |                           |                                     |                       |
| Maryland       | 12 shoth and 7 le m   |                               |  | Name/Relationship <i>(Ty</i><br>Bull/Mothe     |   |   |                            |                                      |                 |               |            |                                 |                         | or Town, State,<br>MD 21  |                                     |                       |
| e,             | Healt<br>Healt<br>tem 2   |                               | 20a. Method of D   | isposition                                     |   |   | Place of Disp              | osition (Na                          | me of           |               |            | Date                            |                         | ocation - City o          |                                     |                       |
| ē              | Pages<br>lent of<br>nt: if i<br>ry or   |                               | 1 🗌 Burial<br>4 🗍 Donation   | 2 Cremation 3 □P<br>n 5 □ Other (Specify)      | Removal from S                          | State Sa  | lisbur                     | y Cre                                | mato            | ry 1          | 2/15       | /2005                           | Sali                    | sbury,                    | Marylan                             | d                     |
| Baltimore,     | permit. Pages 1 and 2 should be filed within 72 hours after deem with the marylat Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 271s marked other then "naturel", or thems 23a or 28a-f show any injury or other traumatic event, it a Madical Examination is a collisist at ancilitied at once. | 1                             | 21. 3 gnature of   | Funeral Service Licens                         | 6e                                      |   | ž<br>H                     | 2. Name a<br>Iinmai                  | nd Addre        | ss of Facilit | ty<br>Home | 2                               |                         |                           |                                     |                       |
|                | # 5 5 9   |                               | MM   | r the disease, or compl                        | KNA                                     | 1 M0029   | 5                          | 1673                                 | Some            | erset         | Ave        | . Prin                          | cess                    | Anne,                     | MD 2185                             | е                     |
|                |   |                               | shock, or h  | eart failure. List only of                     | ne cause oprea                          | ach line.                                       |                            |                                      |                 |               |            |                                 |                         |                           | Interval Bet<br>Onset and           | ween<br>Death         |
| 1              | Physician<br>/Medical   |                               | disease or condi<br>resulting in deat  | tion .   | a. Combin                               | ed Drug<br>oras a conse                         |                            | am and                               | renta           | anyı) 1       | ntoxi      | carton                          |                         |                           |                                     |                       |
|                | Examiner  |                               | Sequentially list  | conditions.                                    | b                                       |   |                            |                                      |                 |               |            |                                 |                         |                           |                                     |                       |
|                | ed<br>sit   | Examiner                      | Sequentially list<br>if any, leading to<br>cause. Enter Un<br>Cause (Disease<br>that initiated eve | immediate<br>derlying<br>or injury             | Due to (                                | or as a conse                                   | quence of):                |                                      |                 |               |            |                                 |                         |                           |                                     |                       |
|                | eath certificate be executed<br>attending physicien and<br>for use as the burial-transit  | xan                           | that initiated eve<br>resulting in death   | nts<br>n) Last                                 | c. Due to (                             | or as a conse                                   | quence of):                |                                      |                 |               |            |                                 |                         |                           |                                     |                       |
|                | ysicier<br>ysicier  | cail                          |  | l  | d                                       |   |                            |                                      |                 |               |            |                                 |                         |                           |                                     |                       |
| 68             | certificat<br>nding phy<br>use as th  | Medi                          | IF FEMALE:   |  |   |   |                            |                                      |                 |               |            |                                 |                         |                           |                                     |                       |
| Вох            | death ce  | Physician/Med                 | 23b. Was deced<br>in the past  | ent pregnant<br>12 months?                     |   | come of pregr<br>inth 2 □ Fet<br>ant at time of | af death 3                 | □Ectopic                             |                 | у             |            |                                 |                         | 23d. Date of d<br>Month   |                                     | Year                  |
| P.O.           | D O D   | ysic                          | 1 ☐ Yes<br>9 ☐ Unkno   |  | 9□ Unkno                                |   |                            |                                      |                 |               |            |                                 |                         |                           |                                     |                       |
|                | The law requires that the site has been signed by the bage 2 should be detached.  | by P                          | Part II. Other sig   | nificant conditions co                         | ntributing to de                        | eath but not re                                 | sulting in the             | underlying                           | cause giv       | en in Part!   | l.         | 1                               |                         |                           | to the cause of                     |                       |
| Vital Records, | w require<br>been signal  | ted                           |  |  |   |   |                            |                                      |                 |               |            |                                 |                         | -                         | Probably 4 🗌                        |                       |
| ěč             | has b   | Completed                     | 1  |  |   |   |                            |                                      |                 |               |            | 24a. Wa<br>aut                  | s an<br>opsy<br>formed? | 24b. Were prior to death? | autopsy findings<br>completion of c | available<br>cause of |
| alF            |   | e Co                          | OF Was seen se   | ferred to medical                              |   |   |                            | -                                    |                 | 26 Place      | e of Deat  | h Check only                    | 2□N                     |                           |                                     |                       |
|                | Physician:<br>r this certific<br>ral director,  | To Be                         | examiner?  |  | Hospitaf: 1 ☐ f                         | npatient 2[                                     | ] ER/Outpati               | ent 3 🗆 E                            | Ott AO          |               |            |                                 |                         | 6XOther (Sp               | ecify) SCE                          | NE                    |
| 0              | fing Ph<br>After th<br>funeral  | L:u                           | 27. Manner of D  | eath<br>5 🗌 Pending                            | Pnd Mont                                | of Injury<br>th, Day Year)                      | 28b. Time<br>Injury        |                                      | 28c. Inju<br>Wo |               |            | 28d. Describe                   | how inf                 | ury occurred              |                                     |                       |
| Division of    |   | catl                          | 2 ☐ Accident   | t investigation                                | -                                       | 3/2005<br>of fnjury - At                        | unk                        | M                                    |                 | Yes 2X        | No         | unk<br>28f. Location            | (Street a               | and Number or             | Rural Route Nur                     | nber.                 |
| ΟįΧ            | after din by  | Certification:                | 4 🗆 Homicio  | determined                                     | buifdi                                  | ng, etc. (Spec                                  | eify)                      | orreor, racio                        | y, omco         |               |            | Princes                         | own, Sta                | te) 11210 L               | arwick La                           | me                    |
| _              | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  | Saic                          | 29a. Certifier<br>(Check only  | 1☐ Certifying Phy<br>2☑ Medical Exem           | ysician: To the                         | best of my kr                                   | nowledge, de               | ath occurre                          | d at the ti     | ime, date a   | nd place,  | and due to th                   | e cause(                | s) and manner             | as stated.                          | s)                    |
|                | To the Ho<br>within 24 I<br>To the Fu<br>completel  | Medical                       | one)   |  | and man                                 | ner stated.                                     | ionori arituror            |                                      |                 | se number     | an occur   | . 50 00 010                     |                         |                           | nth, Day, Year)                     |                       |
|                | vit<br>To   | 2                             | 29b. Signatore a   | itel title of certifier                        | Charle                                  |   |                            | 2                                    |                 | ).C.M.        | Ε.         |                                 |                         |                           | 4, 2005                             | •                     |
|                |   |                               | 30. Name and a   | ddress of person who o                         | completed caus                          | se of death (Ite                                | em 23a) (Tyn               | e, Print)                            |                 |               |            |                                 |                         |                           |                                     |                       |
|                |   |                               | TUA  | lon we   | KEN                                     | W   | 111                        | Penn                                 | Stre            | et, I         | Balti      | more,                           | Mary                    | land 21                   | .201                                |                       |
|                | S:<br>Regis   | ate                           | 31. Date filed (A  | fonth, Day, Year)                              | 32. R                                   | legistrar's Sign                                | nature                     | 1                                    | - مو.           |               |            |                                 |                         |                           |                                     |                       |

Senora Benjamin 05-08179 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                | *  |                     | 1 - For<br>State<br>Registrar   | State of M   | aryland                |   | artmer<br>rtificat                    |   |                      | ind Me      | ,                                  | gien<br>Reg. N      | 0000   | L22                                   | 245                |
|----------------|--|---------------------|---|--|------------------------|---|---------------------------------------|---|----------------------|-------------|------------------------------------|---------------------|--|---------------------------------------|--------------------|
|                | Physici<br>/Media  |                     |   | C. Benjamin  |                        |   |                                       |   |                      |             | 2. Date of Dea<br>Month<br>Decembe | D                   | ay Year<br>4 200                                       | 3. Time of 1:15                       | of Death Death     |
| į              | Examir<br>Funeral  | ner                 |   | Hospital Ce  | nter<br>le (In yrs. Ia | ast birthday)   | Che                                   | Verly 1 Year Days                       | Location of          |             | 8. Date of Birt<br>Month, Da       |                     | Prince (9. Bir   | George !                              | or Foreign         |
|                | Director<br>works  |                     | 578-66-6628  Usual Residence of Decedent  10a. State 10b. County  | 10 M 28 F  | 56                     | Yrs.  |                                       |   |                      |             | eptember                           | 28                  | 7, 1949 W  | 10d. Inside (                         |                    |
|                | deeth with the Maryland<br>ma 23a or 28e-f ahow<br>rroust be notifited at  | Director            | Maryland Charl 10e. Street and Number   |  |                        |   | 10f. Zij                              | o Code                                  | White                |             |                                    | 10g. C              | Citizen of What C                                      |                                       | s 2 No             |
|                | n 72 hours after deeth with the Maryla<br>"natural", or Itama 23a or 28e-f ahov<br>valcal Examinat must be notified at | Funeral             | 3604 Bailey PL  | 12. Was Decedent<br>Armed Forces?<br>ad 1 ☐ Yes 2 🛣                | •                      |   | Was Dece<br>if Yes, spe               |   |                      |             | ify Yes or No-<br>ican, etc.)      | -                   | U.S.A.<br>14. Race - Ame<br>Black, Whi                 |                                       |                    |
| 9500-CL:       | within 72 hours after<br>ene.<br>then "natural", or Ite<br>ne Medical Execulne   | Completed by        | 3 ☐ Widowed 4 ☑ Divorced  15. Decedent' (Specify only highes)   | grade completed)   |                        | 16a. Dece   | dent's Usu                            | al Occupa                               | urina most           | of working  | g                                  | 16b.                | Specify: ] Kind of Business                            | Black<br>/Industry                    |                    |
| land 212       | be filed within tal Hygiene. d other than event, the M   | Be                  | Elementary/Secondary (0-12)  17. Father's Name (First, Middle, L  | •  | 5+)                    |   | E                                     |   | VE ASS<br>18. Mother |             | t<br>(First, Middle,<br>Theresa    |                     | ,  | oloyed                                |                    |
| s, maryıa      | s 1 and 2 should I<br>f Heelth and Meni<br>Item 27 Is marke<br>other traumatic   | 2                   | Cleo Be<br>19a. Informant's Name/Relationsh<br>Laurice A. Marshall  | ip (Type, Print)   | Jan B                  | 9011  | Long E                                | low Roa                                 |                      | t Wash      | Route Numbe                        | r, City<br>Mary     | or Town, State,<br>yland 207                           | 74                                    | 3500               |
| Baltimore      | permit. Pages 1 Depertment of H Important: If Ita any Injury or ott  |                     | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp.  21. Signature of Funeral Service L   | ecify)   | Ce                     | -   | Creme                                 | tory,                                   | Inc. I               |             | er 9, 20                           | 15                  | Belts<br>Belts<br>al Hame, 1                           | zille, Me                             | iryland            |
|                | Pnysician<br>/Medical<br>Examiner  | Examiner            | 23a. PArt 1. Enter the disease, or a prock, or heart failure. List of the condition resulting in death)  Sequentially list conditions, if any, leading to limited the cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as  | a conseque             | Do not ent  |                                       | de of dying                             |                      |             | hington,<br>respiratory ar         |                     | C. 20019   | Approxima<br>Interval Be<br>Onset and | etween             |
| .U. BOX 58/5U, | the death certificate be executed<br>y the attending physicien and<br>iched for use as the burial-transil              | Physician/Medical E | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | d. 23c. If yes, outcome 1  | of pregnan             | ncy<br>death 3[   | ⊒Ectopic p<br>] Other (s <sub>f</sub> |   |                      |             |                                    |                     | 23d. Date of de<br>Month                               | livery<br>Day                         | Year               |
| cords, P       | w requires that the de:<br>been signed by the a<br>should be deteched for  | b                   | Part II. Other significant condition  | s contributing to death b  | out not resul          | lting in the u  | nderlying (                           | cause give                              | n in Part I.         |             | 23e. Did to                        |                     | use contribute to                                      | the cause of robably 4                |                    |
| итат жес       | The law<br>ete has b<br>page 2 si  | e Completed         | 25. Was case referred to medical  |  |                        |   |                                       |   | 00 80                |             | 1 Yes                              | sy<br>med?<br>2 □ N | prior to<br>de th?                                     | utopsy findings<br>completion of      | available cause of |
| DIVISION OF VI | or Attending Phys<br>after death.<br>Director: After this<br>in by the funeral di                                      | Certification; To B | examiner?  1 X Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n 4 Homicide determine  | ation 12-4-0<br>of be 28e. Place of Inj                            | iry<br>y Year)         | ER/Outpatier<br>28b. Time or<br>Injury<br>7±50<br>me, farm, str | M Meet, factor                        | 28c. Injury<br>Work<br>1 🗆 Y            | r: 4 🗆 Nur           | vo 28       | Bd. Describe h                     | lence<br>low inju   | mota Vel<br>h anothor<br>and Number or Ri<br>re) Route | hide to                               | U                  |
|                | To the Hospital Within 24 hours a To the Funeral I completely filled   | Medicai             | 29a. Certifier (Check only one)  2X Madical E   | Physician: To the best<br>xaminar: On the basis o<br>and manner st | if examinati           | vledge, deat<br>on and/or in                                    | vestigation                           | at the time<br>, in my op<br>c. License | inion, deat          | i place, an | d due to the d<br>d at the time, d | ause(:<br>date ar   | c) and manner a  | s stated.<br>to the cause(            | (s)                |
| 4              |  |                     | 30. Name and address of person v  | ho completed cause of c  | death (Item            | 23a) (Type.   |                                       | OC                                      |                      |             |                                    |                     | ember 5,   |                                       |                    |
| 1              | Sta<br>Registi   |                     | L ( M G L 31, Date filed (Month, Day, Year) DEC 9 2005  | mis  | rar's Signati          |   |                                       | . Pen                                   | n Str                | eet         | Baltin                             | nore                | e, Maryl   | and 212                               | 201                |

|                     |   |                      | State of Maryland / Depa   |  | •                         | ene                          | Loote  |
|---------------------|---|----------------------|--|--|---------------------------|------------------------------|--|
|                     |   |                      |  | tificate of Death  |                           | g. No. UU5                   | 42246  |
| ı                   | Physici   | an                   | Decedent's Name (First, Middle, Last)  Name of the Property of the Proper      |  | 2. Date of Death<br>Month | Day Year                     | 3. Time of Death                                   |
|                     | /Medio  |                      | Nancy L. Byrdsong  4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death   | December                  | 7 2005<br>4c. County of Deat | 5:58 p <sup>M</sup>                                |
| ı                   | Examir  | ıer                  |  |  |                           |                              |  |
|                     | Funeral   |                      | Washington Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   | Takoma Park If Under 1 Year If Under 24 Hrs.   | 8. Date of Birth          | Montgome<br>9. Bin           | hplace (State or Foreign                           |
| п                   | Director  |                      | 579-58-6581 1 M 2 XF 62 Yrs.   | Months Days Hours Min.   | (Month, Day, 1            | rear) Co                     | cginia   |
|                     | pg &  |                      | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  | cation   | 1-211                     |                              |  |
|                     | faryla<br>sho   | ŏ                    |  |  |                           |                              | 10d. Inside City Limits 1X Yes 2 □ No              |
|                     | 288-  | Director             | D.C. Washingt  | On<br>10f. Zip Code  | 10                        | g. Citizen of What Co        |  |
|                     | 3a or   |                      | 3342 C. Street S.E.  | 20019  |                           |                              | only:  |
|                     | death<br>ms 2   | nera                 |  | Was Decedent of Hispanic Origin? (Spe<br>f Yes, specify Cuban, Mexican, Puerto           | ecify Yes or No-          | USA<br>14. Race - Ame        |  |
| ဖွ                  | or ite  | Fu                   | 1 Never Married 2 Married 1 Yes 2 No   | r Yes, specify Cuban, Mexican, Puerto<br>I□Yes 2☑No <i>Specify</i> :                     | Hican, etc.)              | Black, Whit                  |  |
|                     | within 72 hours after death with the Maryland<br>ene.<br>than "naturel", or items 23a or 28e-f show<br>fa Madical Exartiner maal be rivillied at  | Completed by Funeral | 3 ★ Widowed 4 Divorced Year or Dates:  | Tres Zanto Specify.  |                           | Specify:                     | Black  |
| 2                   | "nati   | lete                 | 15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give   | lent's Usual Occupation<br>kind of work done during most of worki<br>DO NOT use retired) | ing 10                    | Sb. Kind of Business/        | Industry   |
| 7                   | with!<br>ene.<br>than   | E G                  | Elementary/Secondary (0-12) College (1-4or 5+)   | retary   |                           | ederal Gov                   | vernment   |
| 2                   | Hygi<br>other<br>ent, I   | Be C                 | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name  |                           |                              | CIIIIICIIC   |
| a                   | denta<br>denta<br>rked<br>rked  | To B                 | Minor Walter Burrell   | Blanche  | Welch                     |                              |  |
| Maryland 21215-0036 | and N   |                      |  | g Address (Street and Number or Rura   | al Route Number,          | City or Town, State, 2       | Zip Code)  |
| ≥ .                 | and and m 27  |                      | Michael Byrdsong/Son 7303  | Denmeade Ave., Ft  |                           | ton, MD                      | 20744  |
| ore                 | ges 1<br>t of H<br>if ite   |                      |  | natory or other place)   |                           | c. Location - City or        |  |
| <u>=</u>            | tment<br>tent:  |                      | '4 □Donation 5 □Other (Specify) Fort Linco   | oln Cemetery 12/1  |                           |                              | MD   |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinet must be notified at ance. |                      | 21. Signature of Funeral Service Licensee  | Name and Address of Facility<br>Ort Lincoln Funera<br>OI Bladensburg Rd                  | 1 Home                    |                              |  |
|                     | 40.00   |                      | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter   | tul Bladensburg Rd   | ., Brent                  | wood, MD                     | 20722<br>Approximate                               |
| Ь                   |   |                      | snock, or heart failure. List only one cause on each line.   | ^  | or respiratory arres      | ι,                           | Interval Between<br>Onset and Death                |
|                     | Physician<br>/Medical   |                      | disease or condition resulting in death)  Due to (or as a consequence of):   | SYMPROME   |                           |                              |  |
| В                   | Examiner  |                      | DAVITIAAR  | 1/1/1  |                           |                              |  |
|                     |   | ner                  | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury  | V () V   |                           | -                            |  |
|                     | acuted<br>ind<br>transi   | Examiner             | that initiated events c.   |  |                           |                              |  |
| 760,                | s be executed<br>sicien and<br>burial-transit   |                      | resulting in death) Last Due to (or as a consequence of):  |  |                           |                              |  |
| <u> </u>            | ate<br>the  | dlcal                | d.   |  |                           |                              |  |
| 39 ×                | leath certific<br>attending p   | Physician/Med        | IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnancy   |  |                           |                              |  |
| P.O. Box            | atten<br>I for u  | clan                 | in the past 12 months?   | Ectopic pregnancy Other (specify)  |                           | 23d. Date of deli<br>Month   | Day Year   |
| o.                  | the cachec  | hysl                 | 9 Unknown 9 Unknown  | ,,,  |                           |                              |  |
|                     | w requires that the de<br>been signed by the s<br>should be detached  |                      | Part II. Other significant conditions contributing to death but not resulting in the ur  | iderlying cause given in Part I.   | 23e. Did toba             | cco use contribute to        | the cause of death?                                |
| Records,            | en sig  | Completed by         | FAILED DIALYSIS ACCESS, ENDSTA   |  | , 1 ☐ Yes                 | 2.21 No 3 □ Pr               | obably 4 Unknown                                   |
| ecc                 | law reas be   | plet                 | HYPELICALISMIA, HYPETITENSION, D   |  | 24a. Was an autopsy       | 24b. Were au                 | topsy findings available<br>completion of cause of |
| <u> </u>            | ıysician: The lav<br>iis cerlificate has<br>director, page 2  | Con                  | VENTILLUAX TACHYCATOIA, SHOC   | K.   | performe                  | d2 death?                    | 2 □ No   |
| /ita                | clan:<br>ertific  | Be                   | 25. Was case referred to medical examiner?   |  | (Check only one)          |                              |  |
| of                  | Physi<br>this c   | 7<br>2               | 1   Yes No Hospital: Unpatient 2   ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time of  |  | me 5 Residen              | ce 6 ☐Other (Spec            | cify)  |
| u                   | dlng<br>h.<br>After<br>funer  | tlon                 | 1 Natural 5 ☐ Pending (Month, Day Year) Injury   | 28c. Injury at<br>Work?<br>M 1 ☐ Yes 2 ☐ No  | 28d. Describe how         | injury occurred              |  |
| Division of Vital   | i or Attending Phefer death. Director: After the in by the funeral  | fica                 | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, stre  |  | 28f. Location (Stre       | et and Number or Ru          | ral Route Number                                   |
|                     | al or a setter  | Certification:       | 4 Homicide determined building, etc. (Specify)   |  | City or Town,             | State)                       |  |
|                     | ospit<br>hours<br>unere   |                      | 29a. Certifier  (Check only  (C | occurred at the time, date and place,  | and due to the cau        | se(s) and manner as          | stated.  |
|                     | To the Hospital or within 24 hours efte To the Funeral Dircompletely filled in  | Medical              | one) 2   Medical Examiner: On the basis of examination and/or inv  | restigation, in my opinion, death occurre  | ed at the time, date      | e and place, and due         | to the cause(s)                                    |
|                     | With To   | 2                    | 29b. Signature and title of certifier  R - Smann Smann  R - Smann Smann  R - Smann Smann  R - Smann Smann  R - Smann Smann  R - Smann Smann  R - Smann Smann  R - Sma | 29c. License number  | 290                       | I. Date signed (Month        | Day, Year)   |
|                     | 80  |                      |  | D 53367  |                           | ELEMISER                     | 8", 2005   |
|                     | (3)   |                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, IV SIV DALMES TOWN RIAD, SVINS, 20   | Print) SHYMMSUMAN  | L, DYADAN                 | 020                          |  |
|                     | Sta   | te                   | 31. Date filed (Month, Day, Year)  | L, WITTHEASONG   | IVID, LU                  | otr                          |  |
|                     | Registr   |                      | 31. Date filed (Month, Day, Year)  DEC 1 3 2085  | E)   |                           |                              |  |

|  |                | •                | For<br>State<br>Registrar   | State of Ma                                      | ryland                        | -            | artment of H<br>tificate of I              |                                     | Mental H                                   | ygiene<br>Reg. No.        | 005   | 42247   |
|--|----------------|------------------|---|--|-------------------------------|--------------|--|-------------------------------------|--|---------------------------|---|---|
|  |                |                  | 1. Decedent's Name (First, Middle, Las  | t)   |                               |              |  |                                     | 2. Date of E                               | Death Day                 | Year  | 3. Time of Death                                |
| Phys<br>/Me  | iicia<br>edica |                  | Kay Ellen I   | Berger   |                               |              |  |                                     |  | ber 8                     |   | 4:50 A <sup>M</sup>                             |
| Exar   |                |                  | 4a. Facility Name (If not institution, give   | street and number)                               |                               |              | 4b. City, Town, or                         | Location of De                      |  |                           | ounty of Deat                                   | h   |
|  |                |                  | Southern Mary   |  |                               |              |  | Clinton                             |  |                           |   | George's  |
| Funer  |                |                  | 5. Social Security Number 6. S  | ox /.Age<br>□M 2XXIF                             | (In yrs. lasi                 | Yrs.         | Months Days                                | Hours Mi                            | in. (Month, L                              | Day, Year)                |   | hplace (State or Foreign<br>juntry)             |
| Direct   | or             | -                | 226-80-2616 Usual Residence of Decedent   |  | 51_                           |              |  | l                                   | March                                      | 2, 19                     | 54 L V  | irginia   |
| yland  |                |                  | 10a. State 10b. County  |  | 10c. City, T                  | own or Lo    | cation                                     |                                     |  |                           |   | 10d. Inside City Limits                         |
| e Mar  |                | cto              | Maryland Prince   | George's   |                               |              | Suitla                                     | nd                                  |  |                           |   | 1 X Yes 2 □ No                                  |
| ith the  |                | Olre             | 10e. Street and Number  | 1 . 0  | 11.0                          |              | 10f. Zip Code                              | 207/6                               |  | _                         | en of What Co                                   |   |
| IL Z 1 Z 1 2-00.50<br>filed within 72 hours effer death with the Maryland<br>Hygiene.<br>wither then _naturel', or Itema 23a or 28e-f ehow<br>nit, the Madical Exerging.roughe be nutitional.  |                | Funeral Director | 5619 Regincy I  |  |                               |              |  | 20746                               |  |                           |   | States  |
| er de  |                | nue              | <ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>   | 12. Was Decedent E<br>Armed Forces?<br>1 Yes 2 1 |                               | 13. \        | Was Decedent of Hi<br>f Yes, specify Cuba  | ispanic Origin?<br>n, Mexican, Pu   | (Specify Yes or I<br>erto Rican, etc.)     | No- 14                    | <ol> <li>Race - Ame<br/>Black, White</li> </ol> |   |
| irs eff  |                | ğ                | 3 → Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:                   | •0                            |              | 1☐ Yes 2☐ No                               | Specify:                            |  | s                         | Specify: I                                      | Black   |
| 2 hou  |                |                  | 15. Decedent's Ed   | ucation  | 1                             | 16a. Deced   | ient's Usual Occupa                        | ation                               |  | 16b. Kind                 | d of Business/                                  | Industry  |
| hin 7  |                | pie              | (Specify only highest gra   | College (1-4or 5                                 | +)                            | life. L      | kind of work done of<br>DO NOT use retired | )                                   | vorking                                    |                           |   |   |
| filed within Hygiene.  |                | Completed        |   |  |                               |              | Mail                                       |                                     |  |                           | Govern  | nment   |
| land<br>be fill<br>hental Hy<br>rked oth   |                | Be               | 17. Father's Name (First, Middle, Last)   |  |                               |              |  | 18. Mother's N                      | lame (First, Midd                          | le, Maiden Si             | umame)  |   |
| should be nd Mental marked out   |                | ၉                | David; F.   |  |                               |              |  |                                     | Rosa I                                     |                           |   |   |
| Mar<br>12 sho<br>h and<br>7 is ma<br>traum   | 4              | H                | 19a. Informant's Name/Relationship  | **   |                               |              | ng Address (Street                         |                                     |  |                           |   |   |
| if e) Mal yilalid Z IZ ID-DODO<br>s 1 and 2 should be filed within 72 hours efter death with the Maryla<br>if Heelth and Mental Hygiene.<br>Item 27 is marked other then "nature!", or itema 23a or 28a-1 eho<br>other taumatic event, Ite Modical Exertingurals to nutities) at |                | -                | Denise L. Ben 20a. Method of Disposition  | ger/Daugn  | 20b. Plac                     | e of Dispo   | 51 - 58th sition (Name of                  |                                     | Date Date                                  | -                         | urg, MI<br>ation - City or                      |   |
| Darking Ce, permit. Pages 1 en Depertment of Heel Important: If Item 2 any Injury or other   |                |                  | 1 Burial 2 □ Cremation 3 □  | Removal from State                               | cem                           | etery, cren  | natory or other plac                       | 1                                   | 11/10#                                     |                           | ,   |   |
| mit. Pages<br>pertment of<br>portant: If I   |                |                  | 4 □ Denation 5 □ Other (Specify 21. Signature of Furneral Service Licer                                     | 100  | Gle                           |              | d Cemeter Name and Addres                  | •                                   | /14/05<br>Stewart                          |                           |   | ton, DC   |
| g age  | Book           |                  | John Ti   | Stergar  | TIL                           |              |  |                                     | d., N.E.                                   |                           |   |   |
|  |                | 1                | 23a. Part . Enter the disease, or com<br>shock, or heart failure. List only                                 | olications that caused                           | the death.                    | Do not ent   |  |                                     |  |                           | , 20  | Approximate<br>Interval Between                 |
| Physicia   | an             |                  | Immediate Cause (Final disease or condition   |  |                               | He           | at Foils                                   | 110                                 |  |                           |   | Onset and Death                                 |
| /Medic   | al             |                  | resulting in death)   | a.   | a consequer                   | nce of):     | 0  | 7:                                  |  |                           |   |   |
| Examin   |                |                  | Sequentially list conditions,   | P. C92/  | roint                         | e 1/11       | nex /5.                                    | leedin                              | 7  |                           |   |   |
| be at  |                | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | C to 7   | a consequer                   | (m 1         | 1 FA                                       | lure                                | 9  |                           |   |   |
| xecut<br>and   |                | хап              | that initiated events resulting in death) Last  | c. Due to (or as                                 | a consequer                   | nce of):     | 1 0  |                                     | - 7  |                           |   |   |
| oor ou, icate be executed physicien and s the burial-transit   |                | edical           |   | 702  | emi                           | 5            | UPUS F                                     | NIA                                 | om 0 %.                                    | 515                       |   |   |
| DO<br>ifficate<br>g phy<br>as the  | 3              |                  |   |  |                               |              | -  | 1                                   |  |                           | 11  |   |
| h cert<br>andin  |                | 2                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome                             |                               |              | Ectopic pregnancy                          |                                     |  | 23                        | d. Date of deli                                 | ivery   |
| law requires that the death certifies been signed by the ettending 2 should be detached for use a.   |                | Physician/M      | in the past 12 months? 1 Yes 2 No   | 4☐Pregnant at                                    |                               |              | Other (specify)                            |                                     |  |                           | Month   | Day Year  |
| at the diby the etach  |                | ج<br>چ           | 9 Unknown   |  |                               |              |  |                                     |  |                           |   |   |
| ds,<br>uires the<br>signed<br>d be d   |                | <u>م</u>         | Part Fother significant conditions of   | ontrouting to death bu                           | T not resultil                | og in the ui | of R                                       | en in Part I.                       |  |                           |   | othe cause of death?                            |
| v requ<br>been<br>should   |                | eted             | Cutacking L   | to sento   |                               |              | //   |                                     | -  |                           |   |   |
| e law<br>hest  |                | Completed        | INTECTION, 1)   | y still an                                       | SIVA                          |              |  |                                     | - 24a. We                                  | as an<br>topsy<br>rformed | 24b. Were au prior to death?                    | topsy findings available completion of cause of |
| Or Vital net Physician: The lav this certificate hes ral director, page 2  |                | -                | OS Was assessed to madical  |  |                               |              |  |                                     | 1 ☐ Yes                                    | 2, 2 No                   | 1 ☐ Yes   | 2□ No   |
| sicia<br>s certi   |                | o Be             | 25. Was case referred to predical examiner?  1 Yes 2 146  | Hospital: 1 Inpatie                              | ot 2 TEE                      | VOutpatier   | nt 3 DOA Oth                               | or                                  | Death (Check onl)<br>g Home 5 ☐ Re         |                           | Cothes (Co-                                     |   |
| g Phy<br>erthis  |                | $\vdash$         | 27. Manner Teath  | 28a. Date of Injur                               | ry 28                         | Bb. Time of  |  |                                     | 28d. Describ                               |                           |   | ciry)   |
| Attending at death. ector: Afte by the func  |                | atio             | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation   |  | y rear)                       | Injury       |  | Yes 2 □ No                          |  |                           |   |   |
| JIVISION OI VILA or Attending Physician: ifter death. Director: Affer this certific in by the funeral director,  |                | Certification:   | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  | 28e. Place of Injubuilding, etc                  | ury - At home<br>c. (Specify) | e, farm, str | eet, factory, office                       |                                     | 28f. Location<br>City or 7                 | (Street and own, State)   | Number or Ru                                    | ural Route Number,                              |
| Itelo<br>Insaft<br>Insaft  |                |                  |   |  | - 111/- 11                    |              |  |                                     |  |                           |   |   |
| UIVISION OI  To the Hospitel or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.  |                | edicai           | (Check only one)  | yeicien: To the heal                             | examination                   | n and/or in  | restigation, in my o                       | na, date and de<br>pinion, death oc | soci and due to the<br>courred at the time | e, date and p             | nd manner as<br>place, and due                  | stated.<br>to the cause(s)                      |
| o the<br>ithin 2<br>o the  |                | Mec              | 296. Signature and title of certifier   | and manner sta                                   | IIdu.                         |              | 29c. Licens                                | e number                            |  | 29d. Date                 | signed (Mont                                    | h, Day, Year)                                   |
| F 3 F 8  |                |                  | 100   | V/   |                               |              | 5 /  | 627/                                |  | 1                         | 2/9/0   | 15"   |
| 12   |                |                  | 30. Name and address of person who  | completed cause of d                             | eath (Item 2                  | 38V (Type.   |  | 6374                                | 1 /  | × 3                       | - 1   | 00.0  |
| 191  |                |                  | Anhory  | Com 2 13   | 24                            | Join         | Kein Hur                                   | -SE U                               | Jashing                                    | Jon ()                    | 120   | U3 Z  |
| TE KAN   | Stat           | _                | 31. Date filed (Month, Day, Year)   |  | ar's Signatur                 | θ-           |  |                                     | 7 1  |                           |   |   |
| Reg  | istra          | ar               | BEC 1 3 200   | 13 percent                                       | s JE                          | 1500         | Mes.                                       |                                     |  |                           |   |   |

|                   |  | •                | For 12-19-05 State of Maryland / Department of Heat State of Maryland / Department |                                  | ntal Hygie                              | 711115  | 42248   |
|-------------------|--|------------------|---|----------------------------------|---|---|---|
| 4                 | Physicia   | an               | 1. Decedent's Name (First, Middle, Last) Charles A. Brown   | 2.                               | Date of Death<br>Month<br>Dec. 1        | <sup>Day</sup> , 2005                             | 3. Time of Death  2:30p M                             |
| }                 | /Medic<br>Examin   |                  |   | Marlboro                         | Md.                                     | 4c. County of Death P.G.                          |   |
|                   | Funeral<br>Director  |                  |   | If Under 24 Hrs. 8. Hours Min.   | Date of Birth (Month, Day, Ye May 8,    | 9. Birthp<br>Cour<br>1940 Was                     | lace (State or Foreign try) h.D.C.                    |
|                   | Maryland -f show   | tor              | 10a. State Nd. P.G. 10b. County Upper Marlboro  |                                  |   | 1   | 0d. Inside City Limits 1   Yes 2 No                   |
|                   | 3s or 28e  | Funeral Director | 10e. Street and Number 5605 South Marwood Blvd. 10f. Zip Code 20772   | 2                                | 10g.                                    | Citizen of What Cour                              | ntry?   |
| 036               | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel" or Items 23a or 28e-f show with injury or other traumatic event, Ite Madical Examinant rotal be natilised at once. | by               | 11. Marital Status  1 Never Married 2 Married  3 Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:  |                                  | y Yes or No-<br>an, etc.)               | 14. Race - Americ<br>Black, White,<br>Specify: B1 | etc.  |
| 21215-0036        | d within 72 ho<br>jiene.<br>ir then "netui<br>Ine Medical  | Completed        | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  College (1-4or 5+) 18  16a. Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired) Psychiatric   | ring most of working             |   | . Kind of Business/Ind<br>Rehabila<br>Cente       | tation  |
| Maryland ?        | uld be filed<br>Mental Hyg<br>irked othe   | To Be C          | 17. Father's Name (First, Middle, Last) Richard E. Brown  | 8. Mother's Name (F<br>Mary C.   |   |   |   |
|                   | and 2 sho<br>lalth and N<br>27 Is ma<br>er trauma  |                  | 19a Informant's Name/Relationship (Type, Print) Cheryl Marks - Daughter 72 Hendrick   | d Number or Rural R<br>SS AVe. S | oute Number, Ci<br>Staten               | ty or Town, State, Zip<br>Island N                | Code)<br>. Y. 10301                                   |
| altimore,         | Pages 1 annent of He<br>ant: If iten<br>ury or oth   |                  | 20a. Method of Disposition  1 🔀 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)   | et Dec. 2                        | 21, o5 St                               | Location - City or To<br>aten Isl<br>10           | and, N.Y.   |
| Balt              | permit. Departr Imports eny inji   |                  | 21. Signature of Funeral Service Licensee 22. Name and Address of   |                                  |   | h St. N.W   |   |
|                   | Physician<br>/Medical<br>Examiner  | ner              | 23a. Partive the disease, or complications that caused the beath. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Under vince.  Due to (or as a consequence of):  Due to (or as a consequence of):   |                                  | espiratory arrest,                      |   | Approximate Interval Between Onset and Death4_ months |
| 8760,             | death certificate be executed<br>e attending physician and<br>nd for use as the burial-transit   | dical Examine    | Cause (Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):  d.  |                                  |   |   |   |
| .O. Box 6         | death certif<br>e attending<br>ed for use as   | Physician/Medi   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 5 □ Other (specify) □   |                                  |   | 23d. Date of delive<br>Month                      | ery<br>Day Year                                       |
| ds, P.            | Se us  | by               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Hypertensive Vascular Disease   | in Part I.                       | 23e. Did tobace                         | co use contribute to th<br>2 □ No 3 □ Prob        | ne cause of death?<br>ably 4X\unknown                 |
| of Vital Records, | The law<br>ate has b<br>page 2 sl  | Completed        | Coronary Atery Disease  |                                  | 24a. Was an autopsy performed 1 Yes 2 🔀 | prior to con<br>death?                            | psy findings available appletion of cause of          |
| n of Vita         | ding Physicien: Th<br>h.<br>After this certificate<br>funeral director, pag  | on; To Be        | examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA  Other:  27. Manner of Death 1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  (Month, Day Year)  28b. Time of Injury Work?   | at 28c                           |   | e 6  □Other (Specify                              | /)  |
| Division          | or Attenditer deatl  | Certification;   | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | es 2 □ No 28f.                   | . Location (Stree<br>City or Town, S    | t and Number or Rura<br>tate)                     | l Route Number,                                       |
|                   | Hospitel 4 hours Funerel ely filled  | edical C         | 29a. Certifier (Check only one)  1 XCertifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.  |                                  |   |   |   |
| <b>\</b>          | To the Hos<br>within 24 ho<br>To the Fun<br>completely   | Me               | 29h Signature and title of certifier 29c. License n   | number<br>5618 (D.0              | 29d. D                                  | Date signed (Month, Dec. 13,                      | 0ay, Year)<br>2005                                    |
| 2                 | 5  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Trint)  Lewis W. Marshall MD 1160 Varnum St.  | . N.E. Sı                        | uite 31                                 | 7 Wash,D  | .c.   |
|                   | Sta<br>Regist  |                  | 31. Date filed (Month, Day, Year) DEC 14 2005   |                                  |   |   |   |

|                                 |  |   | 1- State of Maryland / Department / Department / Department / Department / Department / Departme | artment of Health and<br>rtificate of Death  | Mental Hygier                            | tion (or (or (or )) time time it are                                 |  |  |  |  |  |
|---------------------------------|--|---|--|--|--|--|--|--|--|--|--|
|                                 | Physici  |   | Decedent's Name (First, Middle, Last)     MATTIE BOUYER  |  | 2. Date of Death<br>Month DECEMBER       | Oay Year 3. Time of Death 8 2005 2:37 P                              |  |  |  |  |  |
|                                 | /Medic<br>Examin<br>Funeral<br>Director  |   | 4a. Facility Name (If not institution, give street and number)  11103 INVERRARY COURT  5. Social Security Number  6. Sex 1 M 2 K F  98 Yrs.  | 4b. City, Town, or Location of De-<br>BOWIE  If Under 1 Year If Under 24 Hi Months Days Hours Mi | ath 4                                    | 4c. County of Death PEINCE GEORGE'S  9. Birtholace (State or Foreign |  |  |  |  |  |
| 600                             | 0  |   | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo   | ration   | APRIL 12                                 | 1907 ALABAMA  10d. Inside City Limits                                |  |  |  |  |  |
|                                 | Maryla<br>f shov   | lor                                     | MD PRINCE GEORGE'S BOWIE   | cation   |  | 1X Yes 2 □ No  |  |  |  |  |  |
|                                 | r 28a-   | Director                                | 10e. Street and Number   | 10f. Zip Code  | 10g. (                                   | Citizen of What Country?   |  |  |  |  |  |
|                                 | 23a c  | raiD                                    | 11103 INVERRARY COURT  | 20721  |  | J.S.A.   |  |  |  |  |  |
| 36                              | rs after des<br>I', or Iteme   | by Funeral                              | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No   | Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☒ No Specify:     | (Specify Yes or No-<br>erto Rican, etc.) | 14. Race - American Indian, Black, White, etc.  Specify: BLACK       |  |  |  |  |  |
| 215-0036                        | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 ie marked other then "natural", or Iteme 23a or 28a-f show or other traumatic event. It a Medical Examinat must be notified at   | Completed                               | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  | dent's Usual Occupation kind of work done during most of w DO NOT use retired)                   | vorking                                  | Kind of Business/Industry  |  |  |  |  |  |
| 2                               | Hygier<br>Hygier<br>ther th  | Cor                                     | 8TH DAY  | Y CARE PROVIDER  | ame (First, Middle, Maid                 | RIVATE   |  |  |  |  |  |
| au                              | id be i<br>ental i<br>ked oi<br>ic eve   | To Be                                   |  | ANNIE  | HERNS                                    |  |  |  |  |  |  |
| Maryland                        | nd 2 shou<br>alth and M<br>27 le mar<br>or traumat   |   | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailir   | ng Address (Street and Number or )  3 INVERRAY COURT   |  |  |  |  |  |  |  |
| Baltimore,                      | permit. Pages 1 and Department of Heall Important: If item 2 eny injury or other Once.   |   | 1 M Burial 2 Uremation 3 Hemoval from State  | sition (Name of natory or other place)  OLN CEMETERY 12/   |  | Location - City or Town, State ENTWOOD, MARYLAND                     |  |  |  |  |  |
| Balti                           | permit. Departn Importa eny inju   |   |  | 2. Name and Address of Facility J<br>474 LANDOVER ROAL   |  |  |  |  |  |  |  |
|                                 | Physician<br>/Medical<br>Examiner  | iner                                    | 23a. Part 1. Enter the lisease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. MY 6 CARD (ATD)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)   | INFARCTION   | )  | Approximate Interval Between Onset and Death  Y                      |  |  |  |  |  |
| 68760,                          | es that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit   | Completed by Physician/Medical Examiner | that initiated events resulting in death) Last   | INEUNIONI A  |  | ~ / hx   |  |  |  |  |  |
| O. Box                          | Physician: The law requires that the death certi<br>r this certificate has been signed by the attending<br>rail director, page 2 should be detached for use a  |   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown  | Ectopic pregnancy Other (specify)  |  | 23d. Date of delivery<br>Month Day Year                              |  |  |  |  |  |
| Division of Vital Records, P.O. | w requires that in the second properties of th |   | Part II. Other significant conditions contributing to death but not resulting if the u   | nderlying cause given in Part I.   |  | o use contribute to the cause of death?  21 No 3 Probably 4 Unknown  |  |  |  |  |  |
|                                 | The law reate has bee page 2 sho   |   |  |  | 24a. Was an autopsy performed?           |  |  |  |  |  |  |
|                                 | ician:<br>certific<br>ector,   | Be                                      | 25. Was case referred to medical examiner?   | 0.4  | eath (Check only one)                    |  |  |  |  |  |  |
|                                 | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | ation: To                               | 1   Tes 2 25-No 1   Impatient 2   EH/Outpatient 3   DOA 4   Nursing Home 5   Residence 6   Other (Specify)   |  |  |  |  |  |  |  |  |
| Divis                           | ne Hospital or Attending P<br>24 hours after death.<br>ne Funeral Director: After I<br>bletely filled in by the funera   | Certification:                          | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route N City or Town, State)  |  |  |  |  |  |  |  |  |
|                                 | To the Hospil<br>within 24 hour<br>To the Funer<br>completely fill   | Medical                                 | 29a. Certifier (Check only one)  1 (X) Certifying Physicien: To the best of my knowledge, deatly one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.  | vestigation, in my opinion, death oc   | curred at the time, date a               | and place, and due to the cause(s)                                   |  |  |  |  |  |
| <b>\</b>                        | To T<br>To 1   | Σ                                       | 29b. Signature and title of certifier  | 29c. License number  |  | Date signed (Month, Day, Year)                                       |  |  |  |  |  |
| Λ                               | TE   |   | J. J.  |  | ( 7                                      | 12-9-05  |  |  |  |  |  |
| 1                               | (3)  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, 5- M - NAYAR MD 3717 3   |  | E CITY,                                  | MD 20722   |  |  |  |  |  |
| 4                               | Sta<br>Regist  | ate<br>rar                              | 31. Date filed (Month, Day, Year) DEC 1 4 2005   | R's  |  |  |  |  |  |  |  |

|            |  |                | For<br>State<br>Registrar   | Sta                                    | te of I  | Marylan                       |   |                        |                           | lealth a<br>Death          | and M                  | lental Hy                               | giene<br>Reg. No:          | 00        | 5                           | 422                            | 250         |
|------------|--|----------------|---|--|--|-------------------------------|---|------------------------|---------------------------|----------------------------|------------------------|---|----------------------------|-----------|-----------------------------|--------------------------------|-------------|
|            | S 198  | 4              | 1. Decedent's Name (First, Middle   | e, Last)                               |  |                               |   |                        |                           |                            |                        | 2. Date of De                           | ath<br>Day                 | ,         | Year                        | 3. Time o                      | of Death    |
|            | Physici<br>/Medic  |                | Marcus Greg   | ory Ba                                 | llas   |                               |   | ,                      |                           |                            |                        | Dec.                                    | 13                         | 20        |                             | 1:30                           | A M         |
|            | Examir   |                | 4a. Facility Name (If not institution   | -                                      |  |                               |   | 4b. City               | , Town, or                | Location of                | of Death               |   | 4c.                        | County o  | f Death                     |                                |             |
|            |  | 230<br>- 2 42  | Anne Arundel M  |  |  |                               | /                                       |                        | Anna                      | polis<br>  If Under        |                        | 0.0                                     |                            | nne .     |                             |                                |             |
|            | Funeral  |                | 5. Social Security Number 216-94-0890   | 6. Sex<br>1 [ <b>X</b> M 2[            |  | 43                            | last birthday)<br>Yrs.                  | Months                 | Days                      | Hours                      | Min.                   | 8. Date of Bir<br>(Month, Da<br>July 13 | y, Year)                   | 2         | COL                         | olace (State<br>ntry)<br>Jinia | or I-oreign |
| 35         | Director   |                | Usual Residence of Decedent   | _                                      |  | 43                            |   |                        | L                         |                            |                        | pury 12                                 | ,150                       | 2         | A TT C                      | JIIITG                         |             |
|            | yland<br>yland   |                | 10a. State 10b. County  |  |  | 10c. Cit                      | y, Town or Lo                           | cation                 |                           |                            |                        |   |                            |           |                             | 10d. Inside (                  |             |
|            | death with the Maryland<br>ime 23a or 28a-f ehow<br>rmust be notified at                         | ctor           | MD Anne   | Arundel                                |  |                               | Annar                                   | polis                  |                           |                            |                        |   |                            |           |                             | 1 <b>☐</b> ¥e:                 | 2 No        |
|            | he way yan tali ya mana wa wa wa wa wa wa wa wa wa wa wa wa wa                                   | Director       | 10e. Street and Number  |  |  |                               |   | 10f. Zi                | p Code                    |                            |                        |   | 10g. Citiz                 | zen of Wi | hat Cou                     | ntry?                          |             |
|            |  | La L           | 98 Summerfiel   |  |  |                               |   |                        | 21 40                     |                            |                        |   |                            | SA        |                             |                                |             |
|            | er de  | Funeral        | 11. Marital Status  | 12. Was                                | Decede<br>ed Force<br>Yes 2  | ent Ever in U<br>es?<br>Mille |   |                        |                           | ispanic Ori<br>in, Mexican | gin? (Sp.<br>1, Puerto | ecrfy Yes or No<br>Rican, etc.)         | )-                         |           | - Amen<br>, Whit <i>e</i> , | can Indian,<br>etc.            |             |
| 50         | rs aft   | by F           | 1 X Never Married 2 Mar<br>3 Widowed 4 Divorced   | lf Y                                   | es, Give   |                               |   | 1 □ Y <i>e</i> s       | 2 No                      | Specify:                   |                        |   |                            | Specify:  | Whi                         | te                             |             |
| 21215-0036 | 72 hours after<br>natural', or Ite<br>dical Examina  |                | 15. Deceder   | it's Education                         |  |                               | 16a. Dece                               | dent's Usu             | al Occupa                 | ation                      |                        |   | 16b. Kir                   | nd of Bus |                             |                                |             |
| 2          | within 7;<br>iene.<br>rthen "n   | Completed      | (Specify only higher<br>Elementary/Secondary (0-12)   | T                                      | eted)<br>ege (1-4)   | or 5+)                        | (Give                                   | kind of wi<br>DO NOT i | ork done d<br>ise retired | during mos<br>d)           | t of work              | ing                                     |                            |           |                             |                                |             |
| Z          | giene<br>giene<br>r th   | FO.            | 12  |  |  |                               | Cu                                      | stod                   | ial                       |                            |                        | ,                                       |                            | Bake      | ery                         |                                |             |
| and        | be filed<br>ital Hygi<br>id other<br>event.  | Be (           | 17. Father's Name (First, Middle,   | Last)                                  |  |                               |   |                        |                           |                            |                        | a (First, Middle                        |                            | Sumame    | )                           |                                |             |
| Уīа        | should be<br>ind Menta<br>marked<br>umatic ev  | P <sub>C</sub> | Mike Ballas   |  |  |                               |   |                        |                           |                            | -                      | rene Po                                 |                            |           |                             |                                |             |
| = 0        | dand nand le m   |                | 19a. Informant's Name/Relations   |  |  |                               |   | _                      |                           |                            |                        | al Route Numb                           |                            |           |                             |                                |             |
|            | 1 and<br>4ealth<br>9m 27<br>ther to  |                | Betty P. Ballas 20a. Method of Disposition  | s / mot                                | ner  | 20h F                         | 98 S                                    |                        |                           | ld Dri                     |                        | Annap                                   |                            |           |                             | 1403<br>own, State             |             |
| ב<br>ב     | Pages<br>nent of h<br>int: If its  |                | 1 ☐ Burial 2 X Cremation  |  | from Sta   | ate (                         | cemetery, crei                          | matory or              | other plac                | .                          |                        |   |                            |           | •                           |                                |             |
|            |  |                | 4 ☐ Donation 5 ☐ Other (5   |  |  | Met                           |   | -                      |                           | atory<br>ss of Facilit     |                        | 14/2005                                 |                            |           |                             | , VA.                          |             |
| a<br>C     | permit. Departr Importa any Inja   |                | PR  | < D                                    | ٠. ٠٠  | OV                            |   |                        |                           | cain F                     | De                     | eall Fü<br>Bowi                         | nera.<br>e, Ma             |           |                             | 20715                          | 5           |
|            |  |                | 23a. Part1. Enter the disease, o  | complications                          | that cau   | sed the deal                  |   |                        |                           |                            | _                      |   |                            | ar y rc   | 1110                        | Approxima                      | ite         |
| × .        | Physician  |                | shock, or heart failure. List<br>Immediate Cause (Finat   | only one caus                          | e on eac   |                               | ona                                     | Y                      | EN                        | 1601                       | isn                    | 1                                       |                            |           | 14                          | Onset and                      |             |
| Ē.         | /Medical<br>Examiner   |                | disease or condition resulting in death)  a. Due to (or as a consequence of):                               |  |  |                               |   |                        |                           | 700                        |                        |   |                            |           |                             | 1 10                           |             |
|            |  | 1              | Sequentially list conditions b.   |  |  |                               |   |                        |                           |                            |                        |   |                            |           |                             | NON                            |             |
|            | p ii   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | diate Due to (or as a consequence of): |  |                               |   |                        |                           |                            |                        |   |                            |           |                             |                                |             |
|            | be executed<br>ician and<br>burial-transit   | Examin         | that initiated events resulting in death) Last  | c                                      | ue to (or  | as a consec                   | mence of):                              |                        |                           |                            |                        |   |                            |           |                             | _                              |             |
| 8/60,      | cate be executed oblysician and the burial-transit   | calE           |   |  | 10 (0.   |                               | , |                        |                           |                            |                        |   |                            |           |                             |                                |             |
| 200        | certificate<br>Iding phys  | ≂              |   | J                                      |  |                               |   |                        |                           |                            |                        |   |                            |           |                             |                                |             |
| ROX        | eath certific<br>attending pl  | Physiclan/Me   | IF FEMALE:<br>23b. Was decedent pregnant  |  |  | me of pregn                   |   | Te                     |                           |                            |                        |   | 2                          | 3d. Date  | of deliv                    | ery                            |             |
|            | 0 0  | icla           | in the past 12 months?<br>1 □ Yes 2 □ No  | 4                                      | 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) |                               |   |                        |                           |                            |                        | Month Day Year                          |                            |           |                             |                                |             |
| j<br>Ö     | at the<br>by th  | hys            | 9 🗆 Unknown   |  |  |                               |   |                        |                           |                            |                        | _                                       |                            |           |                             |                                |             |
| o,         | requires that the de<br>een signed by the a<br>nould be detached t                               | þ              | Part II. Other significant conditi  | ons contributin                        | g to deat  | h but not res                 | sulting in the u                        | inderlying             | cause giv                 | en in Part I.              | •                      |   |                            |           |                             | he cause of                    |             |
| ecord      | w requir<br>been si<br>should I  | Completed      | - Long ca   | 7((()                                  |  |                               |   |                        |                           |                            |                        | И                                       | Yes 2                      | □No 3     | B ∐ Proi                    | pably 4                        | JUNKNOWN    |
| ပ္သ        | aw<br>S b  | npie           |   |  |  |                               |   |                        |                           |                            |                        | 24a. Was<br>auto                        | psy                        | pr        | or to co                    | opsy findings<br>impletion of  |             |
|            | ate<br>pag   | ပ္ပ            |   |  |  |                               |   |                        |                           |                            |                        | 1 ☐ Yes                                 | 2. No                      |           | ath?<br>Yes                 | 2 / No                         |             |
| Vital      | Physician: Th<br>this certificate<br>ral director, pag   | Be             | 25. Was case referred to medical examiner?  | Hospital                               |  |                               |   | _                      | O.A. Oth                  | or                         |                        | h (Check only                           |                            |           |                             |                                |             |
| ō          | Phys<br>this<br>ral di   | .T             | 1 Yes 2 No 27. Manper of Death  |  | Date of I  |                               | 28b. Time o                             |                        | UA                        | 4 LI NU                    |                        | me 5 Res                                |                            |           |                             | fy)                            |             |
| o          | ding<br>th.<br>After<br>funer  | Certification: | 1 Natural 5 ☐ Pendi   | ng<br>igation                          | (Month,  | Injury<br>Day Year)           | Injury                                  | М                      | Work?                     |                            |                        |   | besome new injury occurred |           |                             |                                |             |
| DIVISION   | or Attending<br>after death.<br>Director: After<br>in by the fune                                | llca           | 3 ☐ Suicide 6 ☐ Could   | not be                                 | Place of   | Injury - At h                 | ome, farm, st                           | reet, facto            | ry, office                |                            |                        | 28f. Location (                         | Street and                 | d Numbe   | r or Rur                    | al Route Nu                    | nber,       |
| 5          | s afte   | Sert           | 4 Homicide  |  | building,  | , etc. (Speci                 | ny)                                     |                        |                           |                            |                        | City of 10                              | wn, State)                 | ,         |                             |                                |             |
|            | To the Hospital or Al<br>within 24 hours after of<br>To the Funeral Directompletely filled in by |                | 29a. Certifier 1/2 Certifyi   | ng Physician:<br>Examiner: On          | To the be  | est of my kno                 | owledge, deat                           | h occurre              | at the tin                | ne, date an                | nd place,              | and due to the                          | cause(s)                   | and man   | ner as s                    | stated.                        | (s)         |
|            | To the H<br>within 24<br>To the F<br>complete  | Aedical        | one)  | an                                     | d manner   | r stated.                     |   |                        |                           |                            |                        |   |                            |           |                             |                                |             |
|            | Marie Con Processing   | Σ              | 29b. Signature and little of certific   | 10/                                    | W  |                               |   |                        | ic. Licens                |                            | 0/                     |   |                            |           |                             | Day, Year)                     |             |
| 0          | n  |                |   | 11/                                    |  | , ,                           |   |                        | 000                       | 717                        | -/                     |   | VEC                        | Cin       | UV                          | 19,0                           | OY _        |
| _          | 124  |                | 30. Name and address of person  | who complete                           | o cause (  | or death (Ite)                | n 23a) (Туре,                           | Print)                 | JR.                       | 100                        | 3 5                    | me 3                                    | 300                        | Ac        | 199                         | 15 M                           | D 2km       |
| 20         | Sta  | ate            | 31. Date filed (Month, Day, Year  |  | A. Reg   | istrar's Sign                 |   |                        | 110                       | , ,                        |                        |   |                            | -         |                             | 4/11                           | 2 0114      |
| 20         | Regist   |                | DEC 14  | 2005                                   | m.   | - 4                           | A Am                                    | 180                    |                           |                            |                        |   |                            |           |                             |                                |             |

|                              |  | •   | 1 - For<br>State<br>Registrar  | State of Ma  |  | epartment o<br>Certificate   |  | and Mental F   | lygiene<br>Reg. No.   | UUUU   | 42251  |
|------------------------------|--|---|--|--|--|--|--|--|---|--|--|
|                              | g.   |   | 1. Decedent's Name (First, Middle, Last)   |  |  |  |  | 2. Date of   |   |  | 3. Time of Death   |
|                              | Physici  |   | Frances Ma   | arie Ca  | arpente  | c  |  | Dec.   | 11  | 2005   | 11:40a <sup>M</sup>  |
|                              | /Medic<br>Examin   |   | 4a. Facility Name (If not institution, give s  |  |  |  | vn, or Location of   | of Death   |   | County of Deat   |  |
| 1                            |  |   | Carroll Hospita  | al Cente   | er   | Wes  | tminst   | er   |   | Carro  | 11   |
|                              | Funeral  |   | 5. Social Security Number 6. Sex   | 7. Age   | (In yrs. last birtho   | lay) If Under 1 Y  | ear If Under   |  | Birth   |  | hplace (State or Foreign   |
|                              | Director   |   | 212-03-9967  | M 2XДF   | 90 Yrs   | Months Da  | ays Hours  | Min. (Month,   | Birth<br>Day, Year)<br>22 191   | 5 Han  | ountry)<br>Nover, PA   |
|                              | σ  |   | Usual Residence of Decedent  |  |  |  |  |  |   |  | ·  |
|                              | ylan   |   | 10a. State 10b. County   |  | 10c. City, Town o  | r Location   |  |  |   |  | 10d. Inside City Limits  |
|                              | Ma-f-s   | to  | MD Carroll   |  | Hampste  | ead  |  |  |   |  | X☐Yes 2☐No   |
|                              | or 28  | Funeral Director  | 10e. Street and Number   |  | -  | 10f. Zip Co  | de   |  | 10g. Cit  | izen of What Co  | untry?   |
|                              | 23a c  | alD   | 4464 Woodsman Dr.  | #522   |  |  | 21074  |  |   | IICλ   |  |
|                              | dea  | ner   | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?  | Ever in U.S.   | 13. Was Decedent   | of Hispanic Ori  | gin? (Specify Yes or<br>n, Puerto Rican, etc.)   | No-   | 14. Race - Ame<br>Black, White   | rican Indian,  |
| 9                            | after<br>or Ite  | F   | 1 Never Married 2 Married  | 1 ☐ Yes 2 N  | io   | 1 ☐ Yes 2√☐  |  |  |   |  |  |
| 5-0036                       | 72 hours after death with the Maryland<br>natural', or Items 23a or 28e-f show<br>disal Examinet must be molified at   | d by  | 3½ Widowed 4 ☐ Divorced  | Year or Dates:   |  | , ,  | 110 Opoony.  |  |   | Specify. Wr  | nite   |
| 5                            | 72 h<br>'natu  | Completed   | 15. Decedent's Educ<br>(Specify only highest grade   |  | (0   | ecedent's Usual O  | ané durina mos   | t of working   | 16b. K  | ind of Business/   | Industry   |
| 21                           | within<br>ene.<br>then *   | dr.   | Elementary/Secondary (0-12)  | College (1-4or 5   | +)   | fe. DO NOT use re  | ,  |  |   |  |  |
| 2                            | filed w<br>Hygiei<br>other tl  | Ö   | 12   |  | 1  | Hairdress  |  |  |   | osmotolo   | ogy  |
| P                            | be fill<br>tal H<br>d otf  | Be  | 17. Father's Name (First, Middle, Last)  |  |  |  | 18. Mothe  | er's Name <i>(First, Mi</i> o  | die, Maiden   | Sumame)  |  |
| <u>×</u>                     | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other then<br>eumatic event, In. M  | ပ္  | Louis Giaraffa   |  |  |  |  | ose DeCo   |   |  |  |
| Maryland                     | 2 sh<br>and<br>Is m  |   | 19a. Informant's Name/Relationship (Typ  |  |  |  |  | er or Rural Route Nu   |   |  |  |
| _                            | es 1 and 2<br>of Health<br>item 27 l   | l X   | Frances Heagerty (   | Daughter   |  |  |  | #522 Ham   |   |  |  |
| ore                          | of H   |   | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re   | emoval from State  |  | isposition (Name of<br>crematory or other  |  | Date   | 20c. Lo   | ocation - City or  | Town, State  |
| Baltimore,                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or Items 23a or 28a-1 show any highry or other freumatic event. The Madical Examiner must be notified at ODGs. |   | '4 ☐ Donation 5 ☐ Other (Specify)  |  | Most Ho  | oly Redee  | mer  | 12-16-05   | Balt  | timore,  | MD   |
| alt                          | Depart<br>Depart<br>Import<br>any in   |   | 21. Signature of Funeral Service License   | 10 11  | 20000  | 22. Name and A   |  |  |   |  |  |
| _                            | 20 = 20  |   | Koland P.  | XHails   | 11/00550   | 934 S. M   | ain St.  | , Hampste  | ad, Mo  | 21074  |  |
|                              |  |   | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on   | cations that caused<br>ie cause on each lin  | the death. Do not<br>ie.   | enter the mode of  | f dying, such as   | cardiac or respirator  | y arrest,   |  | Approximate<br>Interval Between  |
|                              | Physician  |   | Immediate Cause (Final disease or condition  | Exan   | grinah   | on   |  |  |   |  | Onset and Death  |
|                              | /Medical   |   | resulting in death)  |  | onsequence of)   | :  |  |  |   |  |  |
| 1                            |  |   |  |  |  |  |  |  |   |  |  |
|                              | Examiner   |   | Sequentially list conditions b   | Large  | ¿ Gest   | tric   | Vicer  |  |   |  | 2 mon Ry   |
|                              |  | Iner  | Sequentially list conditions, if any, leading to immediate cause. Ener Underlying  | Due to Ss  | a consequence of)  | tric   | Vicer  |  |   |  | 2 mon Ry   |
|                              |  | aminer  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | ·  | a consequence of)  | :  | Vicer  |  |   |  | 2 Man Ry   |
| ,00                          |  | i Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | ·  |  | :  | Vicer  |  |   |  | 2 Men Ry   |
| 3760,                        | te be executed<br>ysician and<br>e burial-transit  | ical  | that initiated events  | ·  | a consequence of)  | :  | Vlcer  |  |   |  | 2 Men Ry   |
| c 68760,                     | te be executed<br>ysician and<br>e burial-transit  | ical  | resulting in death) Last   | Due to (or as a  | a consequence of)  | :  | Vicer  |  |   |  | 2 Men Ry   |
| 9                            | certificate be executed ding physician and se as the burial-transit  | ical  | resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant  | ·  | a consequence of) a consequence of) of pregnancy   | :  |  |  |   | 23d. Date of deli  | ivery  |
| Box 6                        | death certificate be executed e attending physician and id for use as the burial-transit   | ical  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 240 No  | Due to (or as a  | a consequence of) a consequence of) of pregnancy 2 Fetal death   |  | nancy  |  |   | 23d. Date of deli<br>Month   |  |
| O. Box 6                     | death certificate be executed e attending physician and id for use as the burial-transit   | ical  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown   | Due to (or as a d  | a consequence of) a consequence of) of pregnancy 2  Fetal death time of death  | 3 □Ectopic pregn<br>5 □ Other (specif  | nancy<br>(y)   |  | _   | Month  | ivery<br>Day Year  |
| P.O. Box 6                   | ss that the death certificate be executed speed by the attending physician and be detached for use as the burial-transit   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions con  | Due to (or as a  | a consequence of) a consequence of) of pregnancy 2  Fetal death time of death ut not resulting in the  | 3 □Ectopic pregn<br>5 □ Other (specif  | nancy<br>jy)<br>e given in Part I  |  | id tobacco u  | Month use contribute to  | ivery Day Year the cause of death?   |
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| of Vital Records, P.O. Box 6 | ting Physicien: The law requires that the death certificate be executed n. The fact this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit  | Medical Certification; To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a discontinuo de la continuo de la co | a consequence of)  a consequence of)  of pregnancy 2 Fetal death time of death  ut not resulting in the constant of the consta | atient 3 DOA  atient 3 DOA  atient factory, of death occurred at it or investigation, in  29c. Li  | 26. Place Other: 4 Nu Injury at Work? 1 Yes 2 Iffice the time, date an my opinion, dea | 24a. V a p 1   | id tobacco u  Yes 20  Ass an utopsy enformed? s 22 No No Ny one) esidence be how injur  n (Street an Town, State the cause(s) ne, date and          | Month  Use contribute to  No 3   Production of the contribute to death?  1   Yes  6   Other (Special of Number or Rule)  and Mumber or Rule  of place, and due  te signed (Month  2   11   2 | ivery Day Year  In the cause of death?  In the cause of death.  In the cause of death.  In the cause of death.  In the cause of death.  In the cause of death.  In the cause o |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 3:40 P M **Physician** DECEMBER 8, 2005 GERTRUDE GERALDINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner QUEEN ANNE'S CENTREVILLE CORSICA HILLS NURSING HOME If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
NOV. 24, 1919 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 🗶 F MD 86 245-08-1000 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10b. County item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Modical Examinar roust be notified at 1 ☐ Yes 2 No STEVENSVILLE QUEEN ANNE'S Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with USA 21666 901 MONROE MANOR RD. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after WHITE 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) DISABLED permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importent: If item 27 is marked other th any injury or other traumatic event 5 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be GERTRUDE ESTELLE JUREY CHARLES WHITFIELD CAMP 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 804 PETINOT PLACE, STEVENSVILLE, MD SHARON CAMERON/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition CHESAPEAKE CREMATION 12/10/2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive years Pnysician /Medical Due to ( s a consequence of) **Examiner** setergion Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine death certificate be executed and I-trans Due to (or as a consequence of): attending physician a for use as the burial Box 68760. Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? detached for 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes No 2 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death Certification: After To the Hospitel or Attending Matural 5 Pending 1 🗌 Yes 2 No after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide completely filled in by 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 7428H who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persor 1-ASTUN Burgoyne O ICIC Registar's Signature 31. Date filed (Mont) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Ρ 8:41 Aretha Capehart-Sparrow ,2005 Bessie Dec /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 12 F Yrs 62 Director 11,1943 Virginia 227-56-4031 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after deeth with the Maryland Depertment of Heelih and Mental Hygiene. Important: if item 27 is marked other than "naturel", or iteme 23e or 28e-1 ehow empiriquey or other treumatic event, the Modical Evantinating that the colline is an once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits PG MD Temple Hills 1 ☐ Yes 2 ◯XNo Direct 10e. Street and Number 10f. Zip Code 20748 10g. Citizen of What Country? 5959 Fisher Road #202 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) File Clerk U.S. Government 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Albert Capehart Emma Jane Smallwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, George Sparrow/Son 5959 Fisher Rd. #202, TempleHills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/17/05 Norfolk, Virginia Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitGreene Funeral Home, Relson 814 Franklin St.-Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician Known /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the attending physicien and the transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Month Day Year 5 Other (specify) 4 Pregnant at time of death signed by the a ☐Yes 2 100 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has certificete 1 Yes 1 Yes 2 1No the Hospitel or Attending Physicien: Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ N 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature December, 12,05 242 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVGS+00 Yazdani O.M 3 Iwn Sprin 900 31. Date filed (Month, Day, Year) DEC 1 6 2005 2. Registrar's Signature State Registrar

| 1. Decoder Name (Pink Mode), Lard   Hall et Mary Carroll   Mary Carroll   Corrision Hall et Mary    |   |                          |          | 1 - For State Registrar                    | State of Ma                                     | aryland                      | d / Depa      | artmen                     | t of H              | ealth a                   |                          | ental Hy                       |           | e<br>Onna       | F-2-       | 1 00                        | E-m F         |
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| Wilhelm (Since And Market or Print)  18. Mother's Name (First, Middle, Maildes Samumo)  Nora Veronica Reidry  Wilhelm (Since And Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  19. Malling Address (Since and Market or Print)  20. Market of Department of Print Middle, Malling Address (Since and Market or Print)  20. Market of Department of Print Middle, Malling Address (Since and Market or Print)  20. Market of Department of Print Middle, Malling Address (Since and Market or Print)  20. Market of Department of Print Middle, Malling Address (Since and Market or Print)  20. Market of Department of Print Middle, Malling Address (Since and Market or Print)  20. Market of Department of Departme |   | fura<br>a E              | ba<br>Tr | **   |   | 1                            | 16a Dece      | dont's Usua                | al Occupa           | ation                     |                          |                                | 16h k     | Cind of Bus     |            |                             |               |
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| Robert Carroll   Son   106 Aravis Court Grasonville, MD. 21638   20c. Location - City or Town, State of Deposition (Figure 1)   20c. Pieze of Deposition (Figure 2)   27/19/2005   Suitland, MD.   27/19/2005   Suitland, MD.   28/19/2005   Suitland, M | 212<br>W                                    | iene.                    | шo       |  | Collega (1-4or 5                                | +)                           | Но            | omema)                     | ker                 |                           |                          |                                | (         | Own h           | ome        |                             |               |
| Robert Carroll   Son   106 Aravis Court Grasonville, MD. 21638   20c. Location - City or Town, State of Deposition (Figure 1)   20c. Pieze of Deposition (Figure 2)   27/19/2005   Suitland, MD.   27/19/2005   Suitland, MD.   28/19/2005   Suitland, M | פַ פַּ                                      | othe<br>ent,             |          | 17. Father's Name (First, Middle, Last)    |   |                              |               |                            |                     | 18. Mothe                 | r's Name                 | (First, Middle,                | Maide     | n Sumame,       | )          |                             |               |
| Robert Carroll   Son   106 Aravis Court Grasonville, MD. 21638   20c. Location - City or Town, State of Deposition (Figure 1)   20c. Pieze of Deposition (Figure 2)   27/19/2005   Suitland, MD.   27/19/2005   Suitland, MD.   28/19/2005   Suitland, M | <u>a</u>                                    | rked<br>tic e            | 0        | Wilhelm Sirowat                            | ky  |                              |               |                            |                     | Nor                       | a Vei                    | ronica                         | Rei       | dy              |            |                             |               |
| Robert Carroll   Son   106 Aravis Court Grasonville, MD. 21638   20c. Location - City or Town, State of Deposition (Figure 1)   20c. Pieze of Deposition (Figure 2)   27/19/2005   Suitland, MD.   27/19/2005   Suitland, MD.   28/19/2005   Suitland, M | ary<br>sho                                  | ama<br>s ma              |          | 19a. Informant's Name/Relationship (       | Type, Print)                                    |                              | 19b. Mailir   | ng Address                 | (Street a           | nd Numbe                  | r or Rural               | Route Numb                     | er, City  | or Town, S      | tate, Zip  | Code)                       |               |
| Physician Micelical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximation of the cause in the cause of the cau |   | ar tre                   |          | Robert Carroll /                           | Son   |                              | 106           | Aravi                      | s Co                | urt                       | Gra                      | asonvil                        | lle,      | MD.             | 2163       | 38                          |               |
| Physician Micelical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximation of the cause in the cause of the cau | ore<br>1                                    | T tan                    |          |  | Removal from State                              | 20b. Pla                     | nce of Dispo  | sition (Nan<br>natory or o | ne of<br>ther place | θ)                        | Da                       | ite                            | 20c. L    | ocation - C     | ity or To  | wn, State                   |               |
| Physician Micelical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximation of the cause in the cause of the cau | E &   | ent:                     |          |  |   | Ced                          |               |                            |                     |                           |                          | /2005                          | Sui       | tland           | l, MI      | o <b>.</b>                  |               |
| Physician Micelical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximation of the cause in the cause of the cau |   | epart<br>sport<br>ny inj |          | 21. Signature of Funeral Service Licer     | isee )  | 0.0                          | 22            | . Name an                  | d Addres            | s of Facility             | y Bea                    | all Fur                        | nera      | l Hom           | ne         |                             |               |
| Physician (Modical Examiner)  The part II of the significant conditions contribute to the cause of as the part II of the significant conditions contribute to the cause of part II of the significant conditions contribute to the cause of part II of the significant conditions contribute to the cause of part II of the significant conditions contribute to the cause of part II of the significant conditions contribute to the cause of part II of the significant conditions contribute to the cause of part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the significant conditions contribute to the cause of the part II of the part II of the part II of the part II of the part II of the part II of the part II of  | <u> </u>                                    | 25 5 9                   |          | Bus  | in Town   | y                            | 6.            | 512 N                      | W Cr                | ain H                     | wy.                      | Bowie                          | e, M      | D. 2            | 0715       | 5                           |               |
| Physician Medical Examiner    Sequentially is conditional and clease or condition and consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequentially is conditional and sequence of the consulting in death)   Sequence of the consulting in death)   Sequence of the consulting in death   Sequence of the consulting in death   Sequence of the consulting in death   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consulting in the underlying cause given in Part I.   Sequence of the consultin |   |                          |          | shock, or heart failure. List only         | plications that caused<br>one cause on each lin | the death.                   | Do not ent    | er the mod                 | e of dying          | g, such as o              | cardiac or               | respiratory a                  | rrest,    |                 |            | Approximate<br>Interval Beh | ween          |
| Due to (or as a consequence of):    Section   Control    |   |                          |          | disease or condition                       | а.  | WO                           | seps          | 13                         |                     |                           |                          |                                |           |                 |            |                             |               |
| Sequentially list conditions as a consequence of):    Sequentially list conditions are a consequence of):  |   |                          |          | resulting in death)                        | Due to (or as a                                 | a conseque                   | ence of):     |                            |                     |                           |                          |                                |           |                 |            |                             |               |
| Substituting in death) Last    FEMALE:   23c.   If yes, outcome of pregnancy   1   1   25c.   1   25c.   1   25c.  |   |                          | _        | Sequentially list conditions,              |   | 2 00000000                   | 2000 011:     |                            |                     |                           |                          |                                |           |                 |            |                             |               |
| Section   Sect   | pe  | ısıt                     | nine     | Cause (Disease or injury                   | Due to (or as a                                 | a conseque                   | ance on:      |                            |                     |                           |                          |                                |           |                 |            |                             |               |
| Section   Sect   | ,<br>xecu                                   | and al-trai              | xar      | that initiated events                      |   | conseque                     | ence of):     | -                          |                     |                           |                          |                                | -         |                 |            |                             |               |
| FFEMALE: 23b. Was decoded pregnant in the past 12 months?   1   1   1   1   1   1   1   1   1  | 760<br>986                                  | siciar<br>s buri         | ai       | L.   | d   |                              |               |                            |                     |                           |                          |                                |           |                 |            |                             |               |
| The first of the part of the p |   | phy<br>as the            |          |  | - d   |                              |               |                            | _                   |                           |                          |                                |           |                 |            |                             |               |
| The second of th | X Test                                      | use s                    | Z        |  |   |                              |               | lel                        |                     |                           |                          |                                |           | 23d. Date       | of delive  | ery                         |               |
| The second of th | . ga  | e atte                   | icia     |  | 4□Pregnant at                                   |                              |               |                            |                     |                           |                          |                                | i         | Montl           | h          | Day Y                       | /ear          |
| The second of th | O 8   | by th<br>tache           | hys      | 9 🗆 Unknown                                | 9L Unknown                                      |                              |               |                            |                     |                           |                          |                                |           |                 |            |                             |               |
| The second of th | S, lestha                                   | gned<br>be de            | by F     |  |   |                              |               |                            | ause give           | en in Part I.             |                          | 23e. Did t                     | obacco    | use contrib     | ute to th  | ne cause of d               | eath?         |
| The second of th | ord<br>equir                                | ien si<br>ould           |          |  |   | mili                         | ation         |                            |                     |                           |                          | 10'                            | /es 2     | □No 3           | Prob       | ably 4 🗆 U                  | inknown       |
| 25. Was case referred to medical examiner?  1  | e c   | as be<br>2 sh            | ple      | S  | moke  |                              |               |                            |                     |                           |                          |                                |           | 24b. We         | ere auto   | psy findings a              | available     |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29b. Signature and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10c. 15c. 15c. 15c. 15c. 15c. 15c. 15c. 15  |   |                          | Ou       |  |   |                              |               |                            |                     |                           |                          | perto                          | med?      | de              | ath?       |                             | 1430 01       |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29b. Signature and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10c. 15c. 15c. 15c. 15c. 15c. 15c. 15c. 15  | ii a  | artific<br>ctor,         |          | 25. Was case referred to medical examiner? |   |                              |               |                            |                     | A                         | of Death                 | (Check only o                  | ne)       |                 |            | -                           |               |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29b. Signature and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10c. 15c. 15c. 15c. 15c. 15c. 15c. 15c. 15  | Y V   | his collidire            |          | 1 ☐ Yes 2 ☐ MG                             | 1 L Inpatiei                                    |                              | R/Outpatien   |                            | )A                  | 4 Mur                     | rsing Hom                | e 5 🗆 Resid                    | dence     | 6 □Other        | (Specify   | 1)                          |               |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29b. Signature and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10c. 15c. 15c. 15c. 15c. 15c. 15c. 15c. 15  | o de la la la la la la la la la la la la la | Viter t                  | on:      |  | 28a. Date of Injur<br>(Month, Day               | Year) 2                      |               |                            |                     |                           |                          | 3d. Describe I                 | now inju  | ry occurred     | d          |                             |               |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29b. Signature and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10c. 15c. 15c. 15c. 15c. 15c. 15c. 15c. 15  | Sign  | tor: /                   | cati     |  |   |                              |               |                            |                     | /es 2□N                   |                          |                                |           |                 |            |                             |               |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29b. Signature and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  10c. 15c. 15c. 15c. 15c. 15c. 15c. 15c. 15  | N N   | Direction by             | Ħ.       | dataminad                                  | 288. Place of inju                              | iry - At non<br>:. (Specify) | ne, farm, str | eet, factory               | , office            |                           | 28                       | City or Tov                    | street ai | nd Number<br>a) | or Rura    | l Route Numi                | 78 <i>1</i> , |
| 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)   |   | ours<br>eral<br>filled   |          | 29a Certifier VC Certifying Ph             | Veicing: To the hest of                         | of my know                   | ledge death   | occurred :                 | at the tim          | o date and                | d place, as              | od due to the                  | 221122(2  | \ and mane      |            | interest                    |               |
| 22 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  FUPAL R. DESMI 2108 DiDonotto Duve. Chium MD 21619  | Hos   | 24 h<br>Fun<br>etely     | dica     | (Check only 2 Medical Exam                 | niner: On the basis of                          | examination                  | on and/or inv | estigation,                | in my op            | pinion, deat              | h occurred               | d at the time,                 | date an   | d place, an     | d due to   | ated.<br>the cause(s)       | 1             |
| 22 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  FUPAL R. DESMI 2108 DiDonotto Duve. Chium MD 21619  | o t   | of the                   | Me       | 29b. Signature and title of certifier      |   |                              |               | 290                        | . License           | number                    |                          |                                | 29d. Da   | ite signed (    | Month, i   | Day, Year)                  |               |
| 22 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)  FUPAL R: DESM1 21:08 DiDonotto Duve. Chium MD 216.19  | _   | > - 0                    |          | Wedney                                     | W4)   |                              |               | 1                          | 000                 | 6168                      | 8                        |                                |           | 12/16           | 105        |                             |               |
| FUPAL R. DESTAI 2108 DiDonate Dure Chity MD 21619  | 0   | (2)                      |          | 30. Name and address of person who         |   |                              |               | Print)                     |                     |                           |                          |                                |           | •               |            |                             |               |
|  | 14  | (0)                      |          | 6.100                                      |   |                              |               |                            | ve.                 | ant                       | in 1                     | WD 2                           | 161       | 9               |            |                             |               |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  Registrar  DEC 1.6. 2005  |   |                          | all.     | 31. Date filed (Month, Day, Year)          |   | r's Signatu                  | ire /         | . AP =                     |                     |                           |                          |                                |           |                 |            |                             |               |

|                |   | •              | For<br>State<br>Registrar  | State of Ma   | ryland / D.<br>(    | epartmer<br>Certificat                    | t of Health<br>e of Deal              | h and M<br><i>th</i>       |  | giene () () 5                                   | 12255                            |
|----------------|---|----------------|--|---|---------------------|---|---------------------------------------|----------------------------|--|---|----------------------------------|
|                | Physicia  |                | 1. Decedent's Name (First, Middle,   | Last)   |                     |   |                                       |                            | 2. Date of Dea<br>Month                    | ith   | 3. Time of Death                 |
|                | /Medic  |                | AUGUSTUS CAINE   |   |                     |   |                                       |                            | 12   | Day Year<br>12 OF                               | 10:55 A <sup>M</sup>             |
|                | Examin  | er             | 4a. Facility Name (If not institution,   | ,   |                     |   | Town, or Location                     | on of Death                |  | 4c. County of Dea                               |                                  |
|                | Cunaval   |                | SUBURBAN HOSPI'  5. Social Security Number 6   |   | (In yrs. last birth |   | THESDA                                | der 24 Hrs.                | 8. Date of Birth                           | !   | rthplace (State or Foreign       |
|                | Funeral<br>Director   |                | 334-34-3370  | 1 TLM 2 TE  |                     | rs. Months                                | Days Hour                             | rs Min.                    | 8. Date of Birth<br>(Month, Day<br>DECEMBE | R 7, 1928                                       | MONROVIA,LI                      |
|                | g ,   |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town     |   |                                       |                            |  |   |                                  |
|                | ehov  | 5              |  |   |                     |   |                                       |                            |  |   | 10d. Inside City Limits 1    1   |
|                | the N   | Director       | MD MONTGOM  10e. Street and Number   | ERY   | SILVER              | SPRING<br>10f. Zip                        | Code                                  |                            |  | 10g. Citizen of What C                          |                                  |
|                | 3a or   |                | 1400 FENWICK LN  | #606  |                     |   | 910                                   |                            |  | UNITED ST                                       | •                                |
|                | death   | Funeral        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?                                 | ver in U.S.         | 13. Was Dece                              | dent of Hispanic                      | Origin? (Sp                | ecify Yes or No-<br>Rican, etc.)           | 14. Race - Am                                   |                                  |
| 9500-5121      | be filed within 72 hours after death with the Maryland<br>tal Hygiene<br>d other then "naturel", or items 23a or 28a-f ehow<br>event, it a Madical Examinar must be notified at | Ď              | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced   |   | 0                   | 1 🗆 Yes                                   |                                       |                            | rican, etc.)                               | Specify: BI                                     |                                  |
| ,<br>D         | 72 ho   | Completed      | 15. Decedent's (Specify only highest   | Education   | 16a. [              | Decedent's Usu                            | al Decupation                         | nost of work               | ina  | 16b. Kind of Busines                            |                                  |
| 2              | ithin<br>Den.   | np(            | Elementary/Secondary (0-12)  | College (1-4or 5-   |                     | life. DO NOT u                            | se retired)                           |                            | ""9  |   | _                                |
|                | filed w<br>Hygier<br>other th   |                | 17. Father's Name (First, Middle, La   | 5+  |                     |   |                                       | ACHER                      | (Fina Minds)                               | EDUCATION  Maiden Sumame)                       | 1                                |
| and            | d be fundal h   | Be c           | AUGUSTUS F. CA   |   |                     |   |                                       | PANDI                      |  | Maiden Surname)                                 |                                  |
| Maryland 2     | nd 2 should I<br>Ith and Meni<br>27 ie marke<br>r treumatic   | ို             | 19a. Informant's Name/Relationship   |   | 19b.                | Mailing Address                           |                                       |                            |  | r, City or Town, State,                         | Zip Code)                        |
|                | and 2<br>Balth a<br>n 27 le   |                | ESTHER CAINE/  | WIFF.   | 14                  | OO FENW                                   | TCK IN.                               | STLVE                      | R SPRIN                                    | IG. MD 209                                      | 910                              |
| e,             | of H  |                | 20a. Method of Disposition   |   |                     | Disposition (Nation, crematory or control |                                       |                            | Date                                       | 20c. Location - City of                         |                                  |
| Ĕ              | Pages<br>ment of<br>ant: If it<br>ury or o  |                | 1 😡 Burial 2 □ Cremation 3<br>4 □ Donation 5 □ Other (Spe  |   | l .                 | CEMETER                                   |                                       | 1-6-                       | -06 😅                                      | APE MOUNT                                       | COUNTY, LIBER                    |
| Baltimore,     | permit. Page<br>Depertment<br>Important: If<br>eny injury o   |                | 21. Signature of Funeral Service Li  | ensee Wan da  | lley                |   | d Address of Fa                       |                            |  | PITOL MORT                                      | UARY                             |
|                |   |                | 23a. Part1. Enter the disease, or conshock, or heart failure. List or                                      | omplications that caused by one cause on each lin                   | the death. Do no    | ot enter the mod                          | e of dying, such                      | as cardiac                 | or respiratory arr                         | IDC 20002<br>rest,                              | Approximate<br>Interval Between  |
| ğ.             | Physician   |                | Immediate Cause (Final disease or condition  |   | PNEUMONI            |   |                                       |                            |  |   | Onset and Death  10 DAYS         |
|                | /Medical<br>Examiner  |                | resulting in death)  |   | consequence of      |   |                                       |                            |  |   | IO DAID                          |
|                | - Xammer  | _              | Sequentially list conditions,  | b. Due to lor as a  | consaguence of      | fl.                                       |                                       |                            |  |   |                                  |
|                | rted  | ulne           | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury | 200 10 10 10 23 2   | Consaguence of      |   |                                       |                            |  |   |                                  |
| <u>_</u>       | execun and in and in land   | Examiner       | that initiated events<br>resulting in death) Last  | c.<br>Due to (or as a   | consequence of      | f):                                       |                                       |                            |  |   |                                  |
| 09/89          | ificate be executed<br>g physiclen and<br>is the burial-transit   | edical         |  | d   |                     |   |                                       |                            |  |   |                                  |
| _              |   | Med            | IF FEMALE:   |   |                     |   |                                       |                            |  |   |                                  |
| žog            | death certifi<br>e ettending<br>id for use as   | Physician/M    | 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome of 1 ☐ Live birth                              | 2 Fetal death       | 3 ⊟Ectopic p                              |                                       |                            |  | 23d. Date of de<br>Month                        | elivery<br>Day Year              |
| o.             | 0 0   | yslc           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4☐ Pregnant at t<br>9☐ Unknown                                      | ime of death        | 5 Other (sp                               | ecify)                                |                            |  |   |                                  |
| 2              | £ 88  |                | Part II. Other significant condition   | s contributing to death bu  | t not resulting in  | the underlying o                          | ause given in Pa                      | art I.                     | 23e. Did to                                | bacco use contribute                            | to the cause of death?           |
| Vital Hecords, | w requires<br>been sign<br>should be  | ed by          | SEPTIC SHOCK   |   |                     |   |                                       |                            | 1 🗆 Y                                      | es 2⊈No 3⊟F                                     | robably 4 DUnknown               |
| ပ္တ            |   | plet           | ACUTE RENAL FAIL   | URE   |                     |   |                                       |                            | 24a. Was a                                 | an 24b. Were a                                  | autopsy findings available       |
| Ĭ              | The<br>ete h<br>page  | Completed      | CEREBRAL VASCULA   | R ACCIDENT  |                     |   |                                       |                            | autop:<br>perfor                           | med? death?                                     | completion of cause of           |
| Z              | cian:<br>artific<br>ector.  | Be             | 25. Was case referred to medical examiner?   | Manaitali   |                     |   |                                       | lace of Deat               | (Check only or                             | ле)   |                                  |
| 6              | this ald  | <u>۲</u>       | 1 Yes 2 No 27. Manner of Death   | Hospital:<br>1 又 Inpatier<br>28a. Date of Injury                    | t 2 ☐ ER/Outp       |   |                                       |                            |  | ence 6 Other (Sp                                | ecify)                           |
| 5              | ding f<br>th.<br>After<br>funer   | tlon           | 1 Naturat 5 Pending 2 Accident investiga   | (Month, Day   | Year) In            | jury                                      | 8c. Injury at<br>Work?<br>1 ☐ Yes 2   |                            | Zou. Describe II                           | ow infully occurred                             |                                  |
| Division       |   | Certification: | 3 Suicide 6 Could no   | t be 28e. Place of Inju   | ry · At home, farr  | m, street, factor                         |                                       |                            | 28f. Location (S                           | treet and Number or F                           | Rural Route Number,              |
| ā              | rs after<br>al Dire<br>ed in b  | Cert           | 4 _ Homelde  | building, etc.  | . (Зреспу)          |   |                                       |                            | City or Tow                                | m. State)                                       |                                  |
|                | ne Hospital or<br>n 24 hours afte<br>ne Funeral Dir<br>bletely filled in l  | Medical        | 29a. Certifier 1 X Certifying (Check only one) 2 Medical Ex  | Physician: To the best of ceminer: On the basis of and manner state | examination and     | death occurred<br>for investigation       | at the time, date<br>, in my opinion, | and place,<br>death occurr | and due to the d<br>red at the time, o     | cause(s) and manner a<br>date and place, and du | as stated.<br>le to the cause(s) |
|                | To the<br>within 2<br>To the<br>complet   | ž              | 29b. Signature and title of certify r  |   |                     | 29  | . License numb                        | er                         | 2  | 29d. Date signed (Mor                           | nth, Day, Year)                  |
| )              |   |                | 1 - Strike   | - mD  |                     |   | D00601                                | 17                         |  | 12/12/05  | 5                                |
|                | (3)   |                | 30. Name and address of person w   |   |                     |   | DOC:                                  | TT T                       | MD   | 20050   |                                  |
|                | Sta   | *0             | ERIC J. PARK  31. Date filed (Month, Day, Year)  |   | DICAL CE            |   | . ROCKV                               | <b>1</b> 111111,           | תוח  | 20850   |                                  |
|                | Registr   |                | DEC 15 20  | 105 Seine   | r's Signature       | in the                                    |                                       |                            |  |   |                                  |

(B) SSAm.

CAINE, AUGUSTUS

|             |  | Í              | For State Registrar  | State o   | f Marylan   | •  | artmen<br>rtificate                            |                          |                                       | and Men                         |                                       | iene<br>.g. No2 0 0 5                      | 42256  |
|-------------|--|----------------|--|---|---|--|--|--------------------------|---------------------------------------|---------------------------------|---------------------------------------|--|--|
|             | Physicia   | an             | 1. Decedent's Name (First, Middle  |   |   |  |  |                          |                                       | 1                               | Date of Deatl                         | Day Yea                                    | 3. Time of Death                                       |
|             | /Medic   | al             | ROSE CARLOVITO  4a. Facility Name (If not institution  |   | mber)   |  | 4b. City.                                      | Town or                  | Location o                            |                                 | CEMBE                                 | 4c. County of De                           |  |
|             | Examin   | er             | FREDERICK MEMO   |   |   |  | FREDI  |                          |                                       |                                 |                                       | FREDERIC                                   |  |
|             | Funeral<br>Director  |                | 5. Social Security Number 020-12-0177  | 6. Sex<br>1 ☐ M 2 🂢 F                             | 7. Age (In yrs.   | last birthday)<br>98 Yrs.                  | If Under<br>Months                             |                          | If Under 2<br>Hours                   | Min. Ju                         | Date of Birth<br>Month, Day,<br>Ly II | 9. B                                       | irthplace (State or Foreign<br>Country)<br>n Eucky     |
|             | pu 🔭   |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c Cit   | y, Town or Lo                              | cation   |                          |                                       |                                 |                                       |  | 10d. Inside City Limits                                |
|             | Aaryla<br>f ehov   | ٥              | Maryland Frede   | rick  |   | ederic                                     |  |                          |                                       |                                 |                                       |  | 1 ☐ Yes 21X No   |
|             | with the had a or 28a-   | Director       | 10e. Street and Number<br>6106 Jefferson   |   | d   |  | 10f. Zip                                       | Code<br>2170             | 3                                     |                                 | 10                                    | 0g. Citizen of What (                      |  |
| 9           | 2 should be filed within 72 hours after death with the Maryland and Mentle Hygiene.  and Mentle Hygiene.  and marked other than "naturel; or items 23s or 28s-f show enmatic event, the Medical Examinar must be notified at | by Funerai     | 11. Marital Status 1 ☐ Never Married 2 ☐ Marr  | Armed Fo  |   |  |  |                          | spanic Orig<br>n, Mexican<br>Specify: | gin? (Specify<br>n, Puerto Rica | Yes or No-<br>n, etc.)                | Black, Wi                                  |  |
| 5-0036      | urel', c   | d by           | 3 Widowed 4 Divorced   | Year or E   | oates:  |  | 1 🗆 Yes  |                          |                                       |                                 |                                       | Specify:                                   | White  |
| 21215-(     | within 72 h  | Completed      | 15. Deceden<br>(Specify only highes<br>Elementary/Secendary (0-12)   | I's Education<br>at grade completed)<br>College ( |   | (Give                                      | dent's Usua<br>kind of wo<br>DO NOT us<br>Home | rk done d<br>se retired, | luring most                           | t of working                    |                                       | 16b. Kind of Busines  Own                  | Home   |
| Maryland 2  | e filed<br>il Hygi<br>other<br>vent, I   | Be             | 17. Father's Name (First, Middle, Unknown  | Last)   |   |  |  |                          |                                       | er's Name <i>(Fir</i><br>nknown | st, Middle, A                         | Maiden Sumame)                             |  |
| Ž           | should<br>nd Me<br>mark<br>umatic  | 2              | 19a. Informant's Name/Relations  | hip (Type, Print)                                 |   | 19b. Maili                                 | ng Address                                     | (Street a                | ınd Numbe                             | or or Rural Ro                  | ute Number,                           | , City or Town, State                      | , Zip Code)  |
|             | and 2<br>selth a<br>n 27 ic  |                | Diana Castle /   | Granddau  |   | _  |  |                          |                                       |                                 | _                                     | derick, M                                  |  |
| Baltimore,  | permit. Pages 1 and 2 should be<br>Department of Healih and Mentia<br>Importent: If Item 27 is marked<br>eny Injury or other treumatic e<br><u>once</u> .  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S  |   |   | Place of Dispo<br>cemetery, cred<br>ithsbu |  |                          |                                       | Date . 2/19/2                   |                                       | 20c. Location - City<br>Smithsbury         | or Town, State   |
| Balt        | permit. Depertr importe eny inje   |                | 21. Signature of Funeral Service   | Thail   | Ley of  | 12   | <u>01 NO</u>                                   | RTH :                    | MARKE                                 | T ST.,                          | FREDI                                 | RAL HOMES<br>ERICK, MD                     | P.A.<br>21701  |
|             | Physician  |                | 23a. Part1. Enter the disease, or<br>shock, or hear failure. List<br>Immediate Cause (Final<br>disease or condition  | complications that only one cause on              | Λ- ,  | h. Do not en<br>ration                     | , /  | )                        | g, such as<br>non C                   | 9                               | spiratory arre                        | est,                                       | Approximate Interval Between Onset and Death  Howy     |
|             | /Medical<br>Examiner   |                | resulting in death)  | Due to  | (or as a gonseo   | quence of):                                | Fan  |                          |                                       |                                 |                                       |  | 1 Hour   |
| 8760,       | cate be executed<br>physician and<br>the burial-transit  | ical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c   | (or as a conseq   |  |  |                          |                                       |                                 |                                       |  |  |
| P.O. Box 68 | eth certifi<br>ttending<br>or use as   | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 1 ☐ Live  | atcome of pregna<br>birth 2 ☐ Feta<br>nant at time of c<br>nown | I death 3                                  | ⊒Ectopic pi<br>⊒ Other <i>(sp</i>              |                          |                                       |                                 |                                       | 23d. Date of o                             | delivery<br>Day Year                                   |
| ds, P.      | uires that the de<br>signed by the a<br>ld be detached t   | Ď              | Part II. Other significant condition   | ons contributing to c                             | death but not res   | sulting in the u                           | inderlying o                                   | ause give                | en in Part I.                         |                                 | 23e. Did tot                          |  | to the cause of death?  Probably 4 □Unknown            |
| l Records,  | Physicien: The law requir<br>this certificete has been si<br>ral director, page 2 should I   | Completed      |  |   |   |  |  |                          |                                       |                                 | 24a. Was a autops perform             | med? prior to death                        | autopsy findings available to completion of cause of ? |
| of Vital    | Physicien:<br>r this certific<br>ral director,   | Be             | 25. Was case referred to medica examiner?  | Hoepital:   |   | 15   |  | I Othe                   |                                       | of Death (Cl                    |                                       |  |  |
|             |  | lon; To        | 1 Yes 2 No  27. Manner of Death 1 Natural 5 ☐ Pendir   | 28a. Date   |   | ER/Outpatie<br>28b. Time o<br>Injury       |  | 28c. Injun<br>Work       | 4 🔲 140                               | 28d.                            |                                       | ence 6 □Other (S<br>ow injury occurred     | pecify)  |
| Division    | or Atten<br>fter deal<br>Sirector:<br>in by the  | Certification; | 2 Accident investi 3 Suicide 6 Could 4 Homicide determ   | not be 28e. Plac                                  | e of Injury - At h<br>ling, etc. (Speci                         |  | _  |                          | .03                                   | 28f.                            | Location (St<br>City or Town          | treet and Number or<br>n, State)           | Rural Route Number,                                    |
|             | To the Hospital within 24 hours a To the Funerei Completely filled   | Medical C      |  | Exeminer: On the I                                |   |  |  |                          |                                       |                                 |                                       | ause(s) and manner<br>ate and place, and c |  |
|             | To the<br>within<br>To the<br>compli   | Me             | 29b. Signature and title of certifie   |   |   |  |  | c. License               |                                       |                                 |                                       | 9d. Date signed (Mo                        |  |
|             |  |                | <b>•</b>   |   |   |  | 0.00   | D43                      | 091                                   |                                 |                                       | 12-17-0                                    | 7  |
| 1           | Ú  |                | 30. Name and address of person   | who completed cau                                 | ise of death (Ite   | m 23a) (Type<br>80/                        | Print)   | th                       | use                                   | Ave                             | Fre                                   | 12-17-0.<br>derick                         | MA   |
|             | Sta<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year,  | C 1 9 2005  | Registra Sign   | ature &                                    | for  | de                       | ,                                     |                                 |                                       | •  |  |

|                   |  |                | 1 - For<br>State<br>Registrar  | State of M   | //arylar                    |  |                       | nt of H<br>te of L           |                            | and Me                    |  | giene<br>Reg. No. 0           | 05                                       | 42257   |
|-------------------|--|----------------|--|--|-----------------------------|--|-----------------------|------------------------------|----------------------------|---------------------------|--|-------------------------------|--|---|
| i                 | Physicia<br>/Medic   |                | 1. Decedent's Name (First, Middle, La<br>Louise  | _  | mas                         |  |                       |                              |                            |                           | Date of Dea<br>Dec . 1                       |                               | )5 Year                                  | 3. Time of Death 6:15p <sub>M</sub>           |
| ı                 | Examin   |                | 4a. Facility Name (If not institution, giv<br>Kingshire Nu   |  |                             | ab   | F                     | , Town, or                   | ille                       | <b>2</b>                  |  | Mor                           | nty of Death                             |   |
| ľ                 | Funeral<br>Director  |                | 5. Social Security Number 054-28-6260 6. S   | Sex<br>I□M 21XTF   | Age (In yrs.                | last birthday)<br>Yrs.                     | If Unde<br>Months     | Days                         | If Under :<br>Hours        | 24 Hrs. (                 | B. Date of Birth<br>(Month, Day<br>3 / 2 1 / | 1909                          | 9. Birth<br>Cou<br>Gr                    | place (State or Foreign<br>intry)<br>EECE     |
|                   | Maryland<br>-f show<br>lied at   | tor            | 10a. State 10b. County Berger  | 1  | 1                           | ty, Town or Lo                             |                       |                              |                            |                           |  |                               |  | 10d. Inside City Limits 1 Yes 2 No            |
|                   | with the<br>3a or 28a  | i Direc        | 10e. Street and Number<br>418 Rutland Av   | renue  |                             |  | 10f. Z                | ip Code<br>0766              | 0                          |                           |  | 10g. Citizen                  | of What Cou                              | ntry?   |
| 020               | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hydiene. Impartment of Health and Mental Hydiene. Internate if the 27 is marked other than "natural", or items 23a or 28a-f show any injuty or other treumatic event, the Medical Examinar must be notified anone. | by Funera      | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Deceder Armed Force 1  Yes 20 If Yes, Give Year or Dates | s?<br>≹No                   |  | Was Decil Yes, sp     |                              | spanic Origin, Mexican     | gin? (Spec<br>, Puerto R  | ify Yes or No-<br>ican, etc.)                | 14. F                         | Race - Ameri<br>Black, White<br>cify: Wh |   |
| 0-012             | ithin 72 ho<br>e.<br>an "natur<br>Medical  | Completed      | 15. Decedent's E<br>(Specify only highest gr.<br>Elementary/Secondary (0-12)   |  | or 5+)                      | 16a. Deced<br>(Give<br>life.               |                       |                              |                            |                           |  | 16b. Kind of                  |  |   |
| מוומעו            | i be filed w<br>ntal Hygier<br>ed other ti<br>event, th  | Be Cor         | 12 17. Father's Name (First, Middle, Last George Zahardi   |  |                             | sec  | Leta                  | ry-B                         | 18. Mothe                  | r's Name (                | First, Middle,<br>Menen                      | Maiden Sum                    |  | ducts   |
| Mary              | id 2 should<br>th and Me<br>17 is mark<br>17 is mark<br>treumation   | 7              | 19a. Informant's Name/Relationship ( James Comas/So  | Type, Print)   |                             |  |                       |                              | nd Numbe                   | r or Rural                | Route Numbe                                  | r, City or Tov                |  | <sup>Code)</sup> 20878                        |
| בום<br>בום<br>בום | Pages 1 arent of Health if Item 3  |                | 20a. Method of Disposition  1 XBurial 2 Cremation 3 C  4 Donation, 5 Other (Specia   |  | 10                          | Place of Dispo<br>cemetery, crer<br>Orge \ | sition (Na            | ame of other place           | 9)                         | Da                        | te   | 20c. Locatio                  | n - City or T                            |   |
| Daillillor        | permit. P<br>Departm<br>Importar<br>any injui  |                | 21. Signature of Funeral Service Lice  | //   |                             | PÎ   | HTLI                  | P Addres                     | r'fn'a                     | LDI                       | FUNER  | AL SE                         | ERVIC                                    |   |
|                   | Physician<br>/Medical<br>Examiner  |                | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)                   | one cause on each  | esti                        | th. Do not ent                             | er the mo             | de of dying                  | , such as                  |                           |  |                               |  | Approximate Interval Between Onset and Death  |
| ,007              | icate be executed physician and the burial-transit   | dicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or a  |                             |  |                       |                              |                            |                           |  |                               |  |   |
| O. BOX O          | The law requires that the death certific<br>site has been signed by the atlending p<br>page 2 should be detached for use as I  | Physician/Mec  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No   | 23c. If yes, outcom<br>1 DLive birth<br>4 Pregnant<br>9 Unknown  | 2 Feta                      | aldeath 3                                  | Ectopic (             | pregnancy                    |                            |                           |  |                               | Date of deliv<br>Month                   | ery<br>Day Year                               |
| ָרָ אָרָ<br>הַאָּ | puires that<br>signed by<br>ild be deta  | by             | Part II. Other significant conditions of atrial fibri  |  | but not res                 | sulting in the u                           | nderlying             | cause give                   | n in Part I.               |                           | 23e. Did to                                  |                               |  | he cause of death?                            |
| necords,          | 2 2 2  | Completed      | hypertension   |  |                             |  |                       |                              |                            |                           | 24a. Was a<br>autops<br>perfor               | med?                          | prior to co<br>death?                    | opsy findings available impletion of cause of |
| וומ               | sian:<br>ertifica<br>ctor, p   | BeC            | 25. Was case referred to medical examiner?   |  |                             |  |                       |                              | 26. Place                  | of Death (                | 1 ☐ Yes<br>Check only or                     | 2 No                          | 1 🗆 Yes                                  | 2LJ N0  |
|                   | To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: Atter this certificate h completely filled in by the funeral director, page  | ဥ              | 1 ☐ Yes 2 ☒ No  27. Manner of Death 1 ☒ Natural 5 ☐ Pending  | Hospital: 1 Inpa  28a. Date of In (Month, I                      | jury                        | 28b. Time of Injury                        |                       | 28c. Injury<br>Work          | 4 <u>A</u> Nui             | 28                        | 5 Resid                                      |                               |  | (y)   |
| DIVISION          | after death<br>after death<br>Director:<br>d in by the   | Certification: | 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined  | e 28e. Place of I  | njury - At h<br>etc. (Speci | ome, farm, str<br>fy)                      |                       |                              | 95 2 1                     |                           | I. Location (S.<br>City or Town              | treet and Nui<br>n, State)    | mber or Rura                             | al Route Number,                              |
|                   | To the Hospital or At within 24 hours after of To the Funerel Directompletely filled in by   | edical C       | 29a. Certifier Check only one) Certifying Pl   | nysician: To the bes<br>niner: On the basis<br>and manner        | of examina                  | owledge, death<br>ation and/or inv         | occurre<br>vestigatio | d at the time<br>n, in my op | e, date and<br>inion, deat | d place, an<br>h occurred | d due to the c<br>l at the time, d           | ause(s) and<br>late and place | manner as s<br>e, and due to             | tated.<br>the cause(s)                        |
|                   |  | Me             | 29b. Signature and title of certifier  | >  |                             |  | 29                    | D28                          |                            |                           | 2  | 9d. Date sign                 |  | Day, Year)<br>, 2005                          |
|                   | 12   |                | 30. Name and address of person who Ravi Passi  | completed cause of MD 860  |                             | n 23a) (Type,<br>cond                      |                       | ue S                         | ilve                       | r Sr                      | rina.  | Md 20                         | 910                                      | <del></del>                                   |
|                   | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  NFC 1 5 20  | 32 Regis   | strar's Sign                | ature                                      | de                    |                              |                            |                           |  |                               |  |   |

|                     |  |                | For<br>State<br>Registrar   | State of Mary  |  | artment of                            |   |   | giene<br>Reg. No.2 ()          | 105                     | 1,2                          | 258              |
|---------------------|--|----------------|---|--|--|---------------------------------------|---|---|--------------------------------|-------------------------|------------------------------|------------------|
| P                   |  |                | Decedent's Name (First, Middle, Las   | t)   |  |                                       |   | 2. Date of De                           | ath                            |                         | 3. Time                      | of Death         |
|                     | Physici  |                | HOWARD ORRAN  | CLINE  |  |                                       |   | Month<br>DECEMBE                        | ER 17.                         | Year<br>2005            | 3:0                          | 5 A <sup>M</sup> |
|                     | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give<br>Saint Joseph 1   | street and number)                                     | enter                                    | 4b. City, Town,                       | or Location of Death                          |   |                                | nty of Death<br>Balti   | more                         |                  |
|                     | Funeral<br>Director  |                | 5. Social Security Number 6. Se 11  | 9X 7. Age (III   | n yrs. last birthday)<br>Yrs.            | If Under 1 Yea<br>Months Days         |   | 8. Date of Bir<br>(Month, Da<br>JUNE 18 | th<br>ly, Year)<br>B, 1917     | Coui                    | place (State<br>ntry)<br>HIO | or Foreign       |
|                     | pu ≱ ∴   | }              | Usual Residence of Decedent  10a. State 10b. County   | 10   | oc. City, Town or Lo                     | ocation                               |   |   |                                |                         | 10d. Inside                  | City Limits      |
|                     | Aaryli<br>f eho  | ច              | MARYLAND WASHING  | TON  |  | TQ.                                   | OONSBORO                                      |   |                                |                         | 1 🗆 Ye                       | s 2X No          |
|                     | 28a-   | Director       | 10e. Street and Number  | ION  |  | 10f. Zip Code                         | OONSDORO                                      |   | 10g. Citizen o                 | of What Cou             | ntry?                        |                  |
|                     | h with   | O E            | 6138 CLEVELANDTOW   | N ROAD   |  |                                       | 21713   |   |                                | U.S                     | .A.                          |                  |
|                     | deat   | Funeral        | 11. Marital Status  | 12. Was Decedent Eve<br>Armed Forces?                  | r in U.S. 13.                            | Was Decedent of<br>If Yes, specify Cu | Hispanic Origin? (S<br>ban, Mexican, Puert    | pecify Yes or No<br>o Rican, etc.)      | )- 14. R                       | ace - Americack, White, |                              |                  |
| 36                  | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Menial Hygiene. Item 27 is marked other then "nature!", or iteme 23s or 28s-f show other traumatic event, the Madical Examinal must be notified at | by Fu          | 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 □Yes 2 X No<br>If Yes, Give<br>Year or Dates:        |  | 1 ☐ Yes 2 ☑ No                        |   |   | Spec                           | cify:                   | WHITE                        |                  |
| Ö                   | hour<br>turel  | ed b           | 15. Decedent's Ed   |  | 16a. Dece                                | dent's Usual Occ                      | upation                                       |   | 16b. Kind of                   |                         |                              |                  |
| 215                 | n na<br>n na<br>Martis   | Completed      | (Specify only highest gra   |  |  | kind of work don<br>DO NOT use retir  | e during most of wor<br>red)                  | rking                                   |                                |                         |                              |                  |
| 212                 | giene<br>giene<br>er the   | E O            | Claire italy/3000/idaly (0 12)  | 4  | ELEC                                     | TRONIC T                              | ECHNICIAN                                     |   |                                | AL GO                   | VERNM                        | ENT              |
| Maryland 21215-0036 | be filed<br>ital Hygi<br>od other<br>event, I  | Be             | 17. Father's Name (First, Middle, Last)   |  |  |                                       | 18. Mother's Nan                              |   | , Maiden Sum                   | ame)                    |                              |                  |
| yla                 | 2 should be<br>and Mental<br>is marked<br>sumatic ev   | ၉              | JAMES A. CLINE  | 5 000  | 405 44-11                                | Add /C4                               | MARY GA'<br>et and Number or Ru               |   | or Cinyor Tou                  | en State 7is            | Codol                        |                  |
| Mar                 | 12 sh<br>h and<br>7 is rr<br>traum   |                | 19a. Informant's Name/Relationship (7<br>BETTY M. CLINE/SF  |  |  | -                                     | NDTOWN RO.                                    |   |                                |                         |                              | 21713            |
| d)                  | 1 and 2<br>Health<br>tem 27  |                | 20a. Method of Disposition  |  | 20b. Place of Disp                       | osition (Name of                      |   | Date                                    | 20c. Locatio                   |                         |                              | 21/13            |
| Jou                 | ages<br>ant of<br>it: If It  |                | 1 Burial 2 XCremation 3 4 Denation 5 Other (Specify   |  |  | matory or other p                     | TORY 12/                                      | 18/2005                                 | CMTTU                          | CDUDC                   | MAD                          | OT A NID         |
| Baltimore,          | permit. Pages i<br>Depertment of t<br>Important: If Ite<br>any injury or ot<br>ance.   |                | 21. Signature of Bungral Service Lices  | S88  | 2  | 2. Name and Add                       | ress of Facility                              | 7606 0                                  |                                |                         |                              | LLAMD            |
| ä                   | Depermine Depermine Impo   |                | rank Mille  | m Paul M.  | Dean B                                   | AST FUNE                              | RAL HOME                                      | Boonsbo                                 |                                |                         |                              | 713              |
|                     |  |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only                                | Dications that caused the                              | e death. Do not en                       | ter the mode of dy                    | ying, such as cardiac                         | or respiratory a                        | rrest,                         |                         | Approxim<br>Interval B       | etween           |
|                     | Physician  |                | Immediate Cause (Final disease or condition   | ACUTE MY   | OCARDIA                                  | AL INFA                               | RCTION  |   |                                | 3                       | Onset an                     | ) Death          |
|                     | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a c                                      |  | DISEA                                 | CC  |   |                                |                         |                              |                  |
|                     | Laminer  | _              | Sequentially list conditions,   | b. Due to (or as a c                                   |  | DISEH                                 | <u> </u>                                      |   |                                | +                       |                              |                  |
|                     | ted<br>nsit  | nine           | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | 500 10 (01 40 20                                       | 3.135 qua.135 3.17.                      |                                       |   |   |                                |                         |                              |                  |
| Ć.                  | sicien end<br>burial-transit   | Examine        | that initiated events<br>resulting in death) Last   | Due to (or as a c                                      | onsequence of):                          |                                       |   |   |                                |                         |                              |                  |
| 8760,               | The law requires thet the death certificate be executed the hes been signed by the ettending physicien end bage 2 should be detached for use as the burial-transit   | dicai          | (   | d  |  |                                       |   |   |                                |                         |                              |                  |
| 9                   | ng ph<br>as th   | Med            | IF FEMALE:  |  |  |                                       |   |   |                                |                         |                              |                  |
| Вох                 | leath certifica<br>ettending ph  | lan/           | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of p                              | Fetal death 3                            | Ectopic pregnar                       | псу   |   |                                | Date of deliv<br>Month  | ery<br>Day                   | Year             |
| 0.                  | at the desired by the estached for   | Physician/Me   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4☐Pregnant at tim<br>9☐ Unknown                        | ne of death 5                            | Other (specify)                       |   |   |                                |                         | ,                            |                  |
| Ω.                  | thet the   |                | Part II. Other significant conditions of  | ontributing to death but r                             | not resulting in the                     | underlying cause                      | given in Part I.                              | 23e. Did                                | tobacco use co                 | ontribute to t          | the cause o                  | f death?         |
| sp.                 | uires<br>sign<br>ld be   | d by           | CONGESTIVE HE   | ART FAILURE  |  |                                       |   | 1 🗆                                     | Yes 2 No                       | 3 Pro                   | bably 4 [                    | Unknown          |
| 00                  | w require<br>been si<br>should t   | lete           |   |  |  |                                       |   | 24a. Was                                |                                | b. Were auto            | opsy finding                 | s available      |
| Re                  | The tav  | Completed      |   |  |  |                                       |   | auto<br>perf                            | ormed?<br>2X No                | death?                  | ompletion of<br>2□ No        | cause of         |
| ita                 |  | BeC            | 25. Was case referred to medical examiner?  |  |  |                                       | 26. Place of Dea                              | ath (Check only                         |                                |                         |                              |                  |
| of Vital Records,   | di S   | 2              | 1 ☐ Yes 2 🕅 No  | Hospital: 1 1 Inpatient                                | 2 ER/Outpatie                            | nt 3L DOA                             |   | Home 5 ☐ Res                            |                                |                         | fy)                          |                  |
| n o                 | ding Ph<br>h.<br>After th<br>funeral   |                | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Y                   | (ear) 28b. Time Injury                   | N W                                   | juryat<br>/ork?<br>□Yes 2 □No                 | 28d. Describe                           | how injury occ                 | curred                  |                              |                  |
| isio                | or Attending<br>ster death.<br>Director: After<br>in by the fune   | cat            | 2 Accident investigation 3 Suicide 6 Could not b  |  | - At home, farm, s                       |                                       |   | 28f. Location                           | (Street and Nu                 | mber or Rur             | al Route N                   | umber.           |
| Division            | or Attended<br>efter deat<br>Director:   | Certification: | 4 ☐ Homicide determined   | building, etc. (                                       | (Specify)                                |                                       | ~   |   | wn, State)                     |                         |                              |                  |
|                     | To the Hospitel or Attenwithin 24 hours effer deatl To the Funeral Director: completely filled in by the   | edical C       | (Check only 2 Medical Exer  | ysicien: To the best of r<br>niner: On the basis of ex | my knowledge, dea<br>camination and/or i | th occurred at the                    | time, date and place<br>y opinion, death occu | e, and due to the<br>urred at the time  | cause(s) and<br>date and place | manner as               | stated.<br>to the cause      | ə(s)             |
|                     | To the b<br>within 24<br>To the F<br>complete  | Medi           | one) 29b. Signature and title of certifier  | and manner state                                       |  |                                       | ense number                                   |   | 29d. Date sig                  |                         |                              |                  |
|                     | N N N N N N N N N N N N N N N N N N N  |                | 1   | 1-5  |  |                                       | 7254  |   | 12                             | 1171                    | 05                           |                  |
|                     |  |                | 30. Name and address of person who  | completed cause of dea                                 | th (Item 23a) (Type                      |                                       |   |   |                                | , (                     |                              |                  |
| c.                  | 2-4  |                |   |  | 1 OSLER                                  |                                       | TOWSON,                                       | MARYL                                   | AND 2                          | 1204                    |                              |                  |
|                     |  | ate            | 31. Date filed (Month, Day, Year)   | 32. Registrar's  | s Signature                              | ,                                     |   |   |                                |                         |                              |                  |
|                     | Regist   | rar            | DLU I 3   | LUUU Illevilu  | ~ B.                                     | mules                                 |   |   |                                |                         |                              |                  |

|                            |  |                | 1 - For<br>State<br>Registrar   | State of M                                    | arylar     |                                  |                       |  | lealth a               | and M              |                                  | jien<br>leg. No |                              | 42259  |
|----------------------------|--|----------------|---|---|------------|----------------------------------|-----------------------|--|------------------------|--------------------|----------------------------------|-----------------|------------------------------|--|
|                            | Physici  | an             | 1. Decedent's Name (First, Middle, Las  | •   |            | 74 7 -                           |                       |  |                        |                    | 2. Date of Dea                   |                 | ž, 20′0°5                    | 3. Time of Death                                     |
|                            | /Medi  | cal            | Carmelo (4a. Facility Name (If not institution, give  | Joseph  |            | Cicala                           |                       | T  |                        | 1 D                | Decembe                          |                 |                              |  |
| 100                        | Examir   | ner            | Calvert Memoria   |   | 1          |                                  |                       |  | Location of Frede      |                    |                                  | 40              | Calve                        |  |
| 5                          | Funeral  |                | 5. Social Security Number 6. S  | ex 7. Ag                                      |            | last birthday)                   | If Unde               | r 1 Year   | If Under               | 24 Hrs.            | 8. Date of Birth                 | 1               |                              |  |
| 生                          | Director   | ij.            | 5//-44-0523   | MM 2□F  | 74         | Yrs.                             | Months                | Days   | Hours                  | Min.               | NOV 2                            | O ,             | 1931 Was                     | thplace (State or Foreign<br>ountry)<br>Shington, DC |
|                            | and  |                | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. Cit   | ty, Town or Lo                   | cation                |  |                        |                    |                                  |                 |                              | 10d. Inside City Limits                              |
|                            | Maryl  | ō              | MD Calver   | · <del>†</del>                                |            | rince I                          |                       | rick   |                        |                    |                                  |                 |                              | 1 ☐ Yes 2 ☑ No                                       |
|                            | r 28a  | Director       | 10e. Street and Number  |   |            |                                  |                       | p Code   |                        |                    |                                  | 10g. Ci         | tizen of What Co             |  |
|                            | th witi  | ai             | 1620 Joe Harr   | ris Road                                      |            |                                  |                       | 206  | 78                     |                    |                                  |                 | U.S.A.                       |  |
|                            | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or Iteme 23a or 28a-f ehow<br>int, the Macintal Examinari Mat De motified at  | Funerai        | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?             |            | J.S. 13.                         | Was Dece<br>f Yes, sp | edent of Hi  | spanic Origin, Mexican | gin? (Sp           | ecify Yes or No-<br>Rican, etc.) |                 | 14. Race - Ame<br>Black, Whi |  |
| 36                         | rs afte  | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced  | 1 XYes 2 ☐<br>If Yes, Give<br>Year or Dates:  | No         | 1                                |                       | 2 💢 No   |                        |                    |                                  |                 | Specify:                     | white  |
| 8                          | 2 hou  |                | 15. Decedent's Ed   | lucation                                      |            | 16a. Dece                        | dent's Usi            | ual Occupa   | ation                  |                    |                                  | 16b. F          | Cind of Business             |  |
| 215                        | e.<br>en "n<br>Mad   | ple            | (Specify only highest gra<br>Elementary/Secondary (0-12)  | de completed) College (1-4or                  | 5+)        | (Give                            | kind of w<br>DO NOT i | ork done d<br>use retired  | during most<br>()      | t of work          | ng                               |                 |                              | ,  |
| Maryland 21215-0036        | ed wii   | Completed      | 11  |   |            | art                              | tist                  |  |                        |                    |                                  |                 | elf empl                     | oyed   |
| and<br>B                   | ntal H   | Be             | 17. Father's Name (First, Middle, Last) Anthony Josep   | h Cical                                       | _          |                                  |                       |  |                        | er's Name<br>Lther | (First, Middle,                  |                 | n Sumame)<br>Lhoun           |  |
| Ž                          | should Ind Men marke   | T <sub>o</sub> | Anthony Josep  19a. Informant's Name/Relationship (7)   |   | a          | 19h Mailir                       | na Addres             | s (Street a  |                        |                    |                                  |                 | or Town, State,              | Zio Codel  |
|                            | od 2 s<br>lith ar<br>27 le<br>r trau   |                | Gloria Lorentze   |   | er         |                                  |                       |  |                        |                    |                                  |                 |                              | NY 12792   |
| Baltimore,                 | of Hear  |                | 20a. Method of Disposition  |   | 20b. F     | Place of Dispo<br>cemetery, crer | sition /Na            | me of  |                        |                    | Date                             |                 | ocation - City or            |  |
| Ĕ                          | Pages<br>ment of I<br>ant: If its<br>ury or o  |                | 1 ☐ Burial 2 【ACremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify   |   |            | ropolit                          |                       |  |                        | 12/1               | 4/05                             | Ale             | xandria                      | , VA   |
| Salt                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other traumatic event, the Mackinal Examiliest is unit by notified at ance. |                | 24. Signature of Funeral Service Licen  | <b>з</b> ее                                   | 7          |                                  |                       |  | s of Facilit           | 1                  |                                  |                 |                              |  |
|                            | 00 = e o   |                | 23a. Part 1. Enter the disease, or comp   | Jula  | ely        |                                  |                       |  |                        |                    |                                  |                 | ings, M                      |  |
| 2                          |  |                | shock, or hear lajure. List only  | one cause on each li                          | ne.        | in. Do not ent                   |                       |  |                        | cardiac (          | or respiratory arr               | est,            |                              | Approximate<br>Interval Between<br>Onset and Death   |
|                            | Physician /Medical   |                | disease or condition resulting in death)  | a. Over de Due to (or as                      |            |                                  | + +                   | ailu   | -e                     |                    |                                  |                 |                              | months   |
|                            | Examiner   |                |   | Dila  | ted        | s. L .                           | outh                  | i (  | 0.5                    | lior               | nyopat                           | ha              |                              | 42400  |
| 2                          | ים פ   | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Due to (or as                                 | a conseq   |                                  |                       |  | y y                    | 1                  | 1901                             | 7               |                              | 9000   |
|                            | ecute<br>and<br>-trans   | Examiner       | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last                               | c. Sever                                      | ^د         | anen                             | ria                   |  |                        |                    |                                  |                 |                              | months   |
| 8760,                      | cate be executed<br>obysicien and<br>the burial-transit  | alE            |   |   |            | o untop                          | 9 - 3                 | -  |                        |                    |                                  |                 |                              | marat l  |
| 687                        | ificate<br>g phys<br>as the  | edical         |   | d   | ,,,,       | 5 05 100                         | 2~10                  |  |                        |                    |                                  |                 |                              | moranz.  |
| Вох                        | The law requires thet the death certificate has been signed by the attending places a should be detached for use as I  | Physician/Me   | tF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome<br>1 ☐ Live birth        |            |                                  | Tectoric r            | pregnancy  |                        |                    |                                  |                 | 23d. Date of de              | ,  |
| о.<br>Ш                    | e deal   | sicia          | in the past 12 months?<br>1 ☐ Yes 2  No<br>9 ☐ Unknown  | 4☐Pregnant a<br>9☐Unknown                     |            |                                  | Other (s              |  |                        |                    |                                  |                 | Month                        | Day Year   |
| <u>a</u>                   | res thet the de<br>signed by the a<br>be detached t  |                | Part II. Other significant conditions of  | ontobuting to death h                         | ut not res | sulting in the u                 | nderhina              | 221169 2014  | on in Bort I           |                    | 23e Did to                       | bacco           | uso contributo t             | the cause of death?                                  |
| Division of Vital Records, | signe<br>signe   | d by           | 0 - 1   | izophre                                       |            | Jaking in the di                 | idelly ing            | cause give   | arair asti.            |                    |                                  |                 |                              | robably 4 □Unknown                                   |
| S                          | w requir<br>been si<br>should I  | iete           | Coize on disc   | 1110  |            |                                  |                       |  |                        |                    | 24a. Was a                       | an .            | 24h Were a                   | stoney lindings available                            |
| Re                         | siclan: The law<br>s certificate has t<br>irector, page 2 s  | Completed      | Beech cell s  | 250   |            |                                  |                       |  |                        |                    | autops                           | sy<br>med?_     | _   death?                   | utopsy lindings available completion of cause of     |
| EZ.                        | lan: intifica  | BeC            | 25. Was case relerred to medical examiner?  | arcinoma                                      |            |                                  |                       |  | 26. Place              | of Death           | 1 ☐ Yes                          | 2 <b>1</b> 000  | 1 ☐ Yes                      | 2 D No   |
| <u>&gt;</u>                | hysic<br>this ce<br>al direi   | ဥ              | 1 ☐ Yes 2 ☑ No  | Hospital: 1 Inpatie                           |            | ] ER/Outpatien                   | t 3 🗆 D               | OA Cthe  | er: 4□Nu               | rsing Ho           | me 5 Resid                       | ence            | 6 ☐Other (Spe                | ocify)   |
| Z<br>U                     | ding P<br>h.<br>After 1<br>funera  | ion:           | 27. Manner of Death 1 Natural 5 ☐ Pending   | 28a. Date of Inju<br>(Month, Da               | y Year)    | 28b. Time of<br>Injury           |                       | 28c. Injury<br>Work  |                        |                    | 28d. Describe h                  | ow inju         | iry occurred                 |  |
| <u>ISI</u>                 | or Attendi<br>after death.<br>Director: A<br>in by the fu  | ficat          | 2 Accident Investigation 3 Suicide 6 Could not be   | F   | urv - At h | ome, farm, str                   | M<br>eet lacto        |  | Yes 2 ☐ i              | -                  | 281. Location (S                 | treet a         | nd Number or P               | ural Route Number,                                   |
| 2                          | after after I Direct   | Certification: | 4 Homicide determined   | building, et                                  | c. (Specil | fy)                              |                       | , oo   |                        |                    | City or Tow                      | n, Stat         | е)                           | arai i loute railibei,                               |
|                            | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page   | edicai C       | 29a. Certifier 1 Certifying Ph  | ysicien: To the best<br>niner: On the basis o | ol my kno  | owledge, death                   | occurred              | at the tim   | e, date an             | d place,           | and due to the c                 | ause(s          | s) and manner as             | s stated.  |
|                            | the Phin 24 the Phin 24 the Phin mplete  | Medi           | one) 29b. Signature and title of certifier  | and manner st                                 | ated.      |                                  |                       | c. License   |                        | - CCGII            |                                  |                 |                              |  |
| )                          | 7 × 0  | -              | 29b. Signature and title of certifier   |   |            |                                  |                       | D 60   |                        |                    |                                  |                 | IZ/2                         |  |
|                            |  |                | 30. Name and address of person who  | completed cause of o                          | eath (Iter | n 23a) (Tvpe                     | 1                     | y 6 U  | 710                    |                    |                                  |                 | 110/1                        | -00>   |
| _                          | 1  |                | ADEEB JABER   |   | PITA       |                                  |                       | RINC   | E F.                   | REC                | ERICK                            | . ~             | 10 20                        | 678  |
| 10                         | Sta  |                | 31. Date liled (Month, Day, Year)  DEC 1  | 32. Registr                                   | ays Signa  | ature                            | 1                     |  |                        |                    |                                  | -               | 10 20                        |  |
| 96.2                       | Registi  | ell            | DLO T   | I Thank                                       | E SELVE    | U 15                             | 1                     | The same of the sa |                        |                    |                                  |                 |                              |  |

State of Maryland / Department of Health and Mental Hygiene 42260 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Philip Nathaniel Cromwell December 6. 2005 4:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 921 Pat Lane Huntingtown Calvert If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 220 92 8689 Yrs. Director Guvana 56 Dec. 8, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28e-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Calvert Huntingtown 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? ŏ 921 Pat Lane 20639 U.S.A. or itsms 23s Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c. Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or itsm sny injury or other traumatic avent, the Mental or other. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Lab Technician 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Feodore Elizabeth Morgan Felix Solomon Cromwell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rebecca M. Cromwell (Wife) 921 Pat Lane, Huntingtown, Maryland 20639 December 12, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Clinton, Maryland Lee Crematory 21. Signature of Fundal Sovie Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael W. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition NASOPHARYNGEAL Physician resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ò Day 4□Pregnant at time of death 5 Other (specify) signed by the all d be detached for ☐Yes 2☐No 9☐ Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Onknown 2 🗆 No 3 ☐ Probably cete hes been signification of the center of 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificete 20No 1 Yes ours after death.

seral Director: Alter this certificatiled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 NO 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 1 (Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 53782 PMY SICIAN DEC, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Verghese, M.D. 11701 Livingston Road, #101, Fort Washington, MD 20744 31. Date filed (Month, Day, Year) UEC - 8 2005 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year December 13, 2003 Anne C. Calloway /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Viamico PENINSULA REGIONAL Salisbun 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛣 F Days Hours 77 215-26-6020 Director -2 - 1928Va. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2 □ No Directo Wicomico Mardela Springs 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Bridge St. 21837 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: ۵ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School School School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 William Irving Collins Audi Newcomb Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Heelth at Important: if Item 27 is any injury or other treu John O. Calloway, husband 501 Bridge St. Mardela Springs, Md. 21837 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State Mardela Memorial Cem. 12-17-05 4 □ Donation 5 □ Other (Specify) Mardela Springs, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Short Funeral Home, Inc. 2 twitt 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. J. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a Examiner Sequentially list conditions, it any learning to in recials cause. Enter Underlying Cause (Disease or injury that initiated events Examine ettending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 ⊟Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 410 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ٩ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 Within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ENG 100 E. CATIBIT m.o. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2005 Registrar

|                  |   |                  | For<br>State<br>Registrar   |                             | State o  | of Maryl                                       | land / De<br><i>C</i>             | partmei<br>e <i>rtifica</i>    |                          |                         |                          |                                   | giene<br>Reg. No.       |                      | 5 4                                 | 2262  |
|------------------|---|------------------|---|-----------------------------|--|--|-----------------------------------|--------------------------------|--------------------------|-------------------------|--------------------------|-----------------------------------|-------------------------|----------------------|-------------------------------------|---|
|                  | Physicia  |                  | 1. Decedent's Name (First, M.  IVA E.   |                             | R T ጥጥ   |  |                                   |                                |                          |                         |                          | 2. Date of De                     |                         |                      | Y°25                                | 3. Time of Death                                |
|                  | /Medic<br>Examin  |                  | 4a. Facility Name (If not institu   |                             |  | ımber)   |                                   | 4b. City                       | , Town, o                | r Location              | of Death                 | 7 0                               | 4c.                     | County               | of Death                            | 7 1111  |
|                  | ZX  | Ĭ.               | Upper Chesa   | peak                        | e Med  |  |                                   |                                |                          | Air                     |                          |                                   |                         | На                   | rford                               |   |
|                  | Funeral   |                  | 5. Social Security Number 187-24-2303   | 6. Sex                      | M 2₫F  |  | yrs. last birthda                 | Months                         | Days                     | Hours Hours             | Min.                     | 8. Date of Bit                    | th<br>1913              |                      | 9. Birthpla<br>Countr<br>West       | ice (State or Foreign<br><sup>y)</sup> Virginia |
|                  | Director  |                  | Usual Residence of Decedent   |                             |  |  |                                   |                                |                          |                         |                          |                                   |                         |                      |                                     |   |
| _                | Maryland<br>-f ehow<br>lied at  | _                | 10a. State 10b. Cou   | nty<br>arfo:                | rd   | 100  | City, Town or אז.<br>הוא          | Location itef                  | ord                      |                         |                          |                                   |                         |                      | 100                                 | d. Inside City Limits 1 ☐ Yes 2 XNo             |
|                  | he Ma<br>8e-f   | ecto             |   | allo.                       |  |  | AA 1.                             |                                | ip Code                  |                         | -                        |                                   | 10g Citi                | izen of V            | What Countr                         |   |
| 0                | 772 hours after death with the Marylar<br>"neturel", or items 23e or 28e-f ehow<br>culcal Examinat must be notified at                            | Funerai Director | 10e. Street and Number 2127 Whit  | efor                        | d Roa  | ıd   |                                   | 101. 2                         |                          | 1160                    | )                        |                                   |                         |                      | d Sta                               |   |
| 2                | death<br>rms 23   | nera             | 11. Marital Status  |                             | 12. Was Dec  | edent Ever                                     | in U.S. 1                         | 3. Was Dec                     | edent of H               | dispanic O              | rigin? (Spe              | ecify Yes or No<br>Rican, etc.)   | 0-                      |                      | e - America                         |   |
| 7 9              | after<br>or Ite   | y Ful            | 1 Never Married 2   |                             | 1 ☐ Yes<br>If Yes, G   | 2 ⊠ No<br>ive                                  |                                   | 1 Tes, sp                      |                          |                         |                          | riiouri, oto.,                    |                         |                      | . Whi                               |   |
| 4 1/             | hours<br>turel',  | ed by            | 3 ∰Widowed 4 □ Divor  | dent's Educ                 | Year or I  | Dates:   | 16a De                            | cedent's Us                    | ual Occur                | nation                  |                          |                                   | 16b Ki                  | ind of Bu            | usiness/Indu                        | ıstry   |
| _ T              |   | Completed        | (Specify only hi  | ghest grade                 | e completed,   | (1-4or 5+)                                     | (G                                | ive kind of w<br>a. DO NOT     | ork done                 | during mo               | ost of work              | ing                               |                         |                      |                                     | •   |
| 212              | <b>₹8₽</b>  | Com              | 8   |                             | - Comogo (   | (1 101 01)                                     |                                   | Home                           | emak                     |                         |                          |                                   |                         |                      | Home                                | 2   |
| 10               | be filed<br>tal Hygi<br>d other<br>event.   | Be               | 17. Father's Name (First, Mid<br>John Work  |                             |  |  |                                   |                                |                          |                         |                          | e (First, Middle<br>cilla         |                         |                      | 10)                                 |   |
| 05               | d 2 should be in and Mental. 7 is marked of treumatic every   | L<br>C           | 19a. Informant's Name/Relat   |                             | oe. Print)   |  | 19b. M                            | ailing Addre                   | ss (Street               |                         |                          | al Route Numb                     |                         |                      | State, Zip C                        | Code)   |
| -                | D = D =   |                  | Norma Wyat  |                             |  | er   |                                   | •                              |                          |                         |                          | itefor                            | -                       |                      | 211                                 |   |
| 12               | - T 5 E   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremat  | an 2 🗀 🛭                    | amoual from  | 20<br>State                                    | 0b. Place of Di                   |                                |                          |                         |                          | Date 105                          |                         |                      | City or Tow                         | m, State  |
| 12/2<br>altimore | Pages<br>ment of I<br>ent: If it<br>ury or o  |                  | '4 □Donation 5 □ Othe   |                             | emoval froit   | 1 State  | Union                             | Chap                           | el (                     | Cem.                    | 12/                      | 27/05                             | De                      | lta                  | , PA                                |   |
| Pal Hall         | permit. Pages<br>Department of<br>Importent: If i<br>any injury or<br>once.   | ja ji            | 21. Signature of Funeral Sen  | vice License                | ee )   | For  | led                               | Hark:                          |                          |                         |                          | Home,                             | Ind                     | c. 1                 | Delta                               | ı, PA   |
|                  | **  |                  | 23a. Part1. Enter the disease<br>shock, or heart failure.   | e, o compli<br>List only or | cations that   | caused the each line.                          | death. Do not                     | enter the mo                   | ode of dyla              | ng, such a              | s cardiac                | or respiratory a                  | rrest,                  |                      | 1                                   | Approximate<br>Interval Between                 |
|                  | Physician   | 0                | Immediate Cause (Final disease or condition   | a                           | 5  | eve  | ve !                              | cesi                           | nro                      | etar                    |                          | ailuv                             |                         |                      |                                     | Onset and Death                                 |
| 7                | /Medical<br>Examiner  |                  | resulting in death)   |                             | Due to   | (or as a co                                    | nsequence of):                    | Arn                            | iva                      | Sim                     | Ph                       | 01.01                             | (na)                    |                      |                                     | 1 da.   |
| (8               | <sup>2</sup> dir  | er               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | , t                         | Due to   | o (or as a co                                  | nsequence of);                    | 1171.                          | 1                        |                         | 171                      | corr                              | 4,00                    | 4                    | _                                   | 17  |
| 3                | cuted br  | Examine          | that initiated events   | 1                           | 5  | eve  | re C                              | evel                           | oral                     | va                      | scul                     | en a                              | ecic                    | deu                  | A _                                 | 11 days   |
| Es               | ate be executed any sician and the burial-transit   |                  | resulting in death) Last  |                             | Due to   |  | nsequence of):                    | (C:1)                          | _                        |                         |                          |                                   |                         |                      | 1                                   | OLIONIS   |
| 3750             | ate ath   | dicai            |   |                             | 1  | 1912   | erter                             | CAIN                           |                          |                         |                          |                                   |                         |                      |                                     | O of ceres                                      |
| 1#               | Box of box of lifting all attending plants as t   | Physician/Me     | IF FEMALE:<br>23b. Was decedent pregnan   | 2                           | 3c. If yes, o  | utcome of pr                                   | regnancy<br>Fetal death           | 3 □Ectopic                     | ~~~~                     |                         |                          |                                   |                         |                      | te of deliver                       |   |
| 11 0             | death<br>death  | sicia            | in the past 12 months?  |                             |  | gnant at time                                  |                                   | 5 Other (                      |                          | · y                     |                          |                                   |                         | Mo                   | nth E                               | Day Year  |
| ه نید            | that the de ed by the a   | Phy              | 9 Unknown Part II. Other significant cor  | ditions cor                 | atributing to  | death but no                                   | tresulting in th                  | e underlying                   | Called di                | ven in Pari             | t I                      | 23e. Did                          | tobacco i               | use cont             | ribute to the                       | cause of death?                                 |
| 187              | The colors, T.C. BOX of The law requires that the death certific the has been signed by the attending page 2 should be detached for use as        | by               | Cheum   | ato                         | d  | Art  | huits                             |                                | oddoo g                  |                         |                          |                                   | ,                       | No                   |                                     | bly 4 Dunknown                                  |
|                  | taw requires as been sign should be   | Completed        | Osteoa  | Liter                       | nits   |  |                                   |                                |                          |                         |                          | 24a. Was                          |                         | 24b.                 | Were autop                          | sy findings available pletion of cause of       |
| _0               | The taw<br>ate has  | mo:              | Gastro  | e Sav                       | show   | eal  | Refl                              | uso 1                          | Ase                      | ase                     | ,                        | auto<br>perf<br>1 Tyes            | ormed?<br>2 <b>X</b> No |                      | prior to com<br>death?<br>1 □ Yes 2 |   |
| 1                |   | BeC              | 25. Was case referred to me examiner?   | dical                       |  | 8  |                                   |                                |                          | 26. Pla                 |                          | h (Check only                     | one)                    |                      |                                     |   |
| 1 .              | VISION OF VITA Attending Physicien: or death. ector: After this certifica by the funeral director.  | 2                | 1 ☐ Yes 2 ▼No<br>27. Manner of Death  |                             | to provide the same of the sam |  | 2 ER/Outpa<br>28b. Tim            |                                | JOA                      |                         |                          | me 5 Res<br>28d. Describe         |                         |                      |                                     |   |
|                  | ding<br>th.<br>After  | tion             | 1 XNatural 5 ☐ Pe   | ending<br>restigation       | (Mo  | e of Injury<br>onth, Day Ye                    | ar) Inju                          | ny M                           | 28c. Inju<br>Wo<br>1 [   | rk?<br>]Yes 2[          |                          |                                   |                         |                      |                                     |   |
| -0               | lor Attending after death.  Director: After lin by the fune   | Certification:   | 3 ☐ Suicide 6 ☐ Ce  | ould not be<br>termined     | 28e. Plac  | ce of Injury -<br>ding, etc. (S                | At home, farm                     | street, facto                  | ory, office              | -                       |                          | 28f. Location<br>City or To       | (Street an              | nd Numb              | er or Rural                         | Route Number,                                   |
|                  | utal or A   |                  |   |                             |  |  |                                   |                                |                          |                         | Į.                       |                                   |                         |                      |                                     |   |
| •                | To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director. | Medical          | 29a. Certifier 1 Cer<br>(Check only 2 Med   | ifying Phy<br>ical Exami    | ner: On the  | he best of my<br>basis of exa<br>inner stated. | y knowledge, d<br>amination and/d | eath occurre<br>r investigatio | d at the ti<br>on, in my | ime, date a opinion, de | and place,<br>eath occur | and due to the<br>red at the time | cause(s)<br>, date and  | ) and ma<br>d place, | anner as sta<br>and due to t        | ited,<br>the cause(s)                           |
| _                | To the within 2 To the comple   | Me               | 29b. Signature and title of ce  | rtifier                     | $\sim$   |  | MAD                               | 2                              | 9c. Licen                | se numbe                | r                        |                                   | -                       |                      | d (Month, D                         | *   |
|                  |   |                  | 1486  | rlli                        | 17   |  | MP                                | H                              | DI                       | 58                      | 21                       |                                   | De                      | CEN                  | user                                | -21,2005  |
|                  | 7   |                  | 30. Name and adviress of pe   | rson who co                 | ompleted car   | use of death                                   | (Item 23a) (Ty                    | pe, Print)                     | 5                        | leg                     | we                       | at a                              | 7 - F                   | ha                   | il R                                | €   |
|                  |   | ata              | 31. Date filed (Month, Day,   | Y ( (                       | 12 2 1 1<br>324  | Registrar's                                    | Signature                         |                                | <b>4</b> 4               | 150                     | 1 H                      | ir, IV                            | 1d.                     | 2                    | 1014                                |   |
|                  | Regist  | ate<br>rar       | DEC 3   | _                           |  | 242  | St A                              | DE VEL                         | 7                        |                         |                          |                                   |                         |                      |                                     |   |

|                |   |                | 1- State of Maryland State of Maryland  |                                | artment of H                                |   |  | iene () (                           | 05 42263   |
|----------------|---|----------------|---|--------------------------------|---|---|--|-------------------------------------|--|
|                | Division  |                | Decedent's Name (First, Middle, Last)   |                                |   |   | 2. Date of Deal                            |                                     | 3. Time of Death   |
|                | Physici<br>/Medic   |                | LEONARD CHIV  | 15                             |   |   | DECEMA                                     |                                     | Zoas 1 - Py M  |
|                | Examin  | er             | 4a. Facility Name (If not institution, give street and number)  NoNTHWEST #85PIT  | 4C                             | 4b. City, Town, or<br>AAW //                | Location of Death                           | WN   | 4c. County                          | TIMIRE   |
|                | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. In 1 ≥ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤ 1 ≤   | ast birthday)<br>Yrs.          | If Under 1 Year<br>Months Days              | If Under 24 Hrs. Hours Min.                 | 8. Date of Birth<br>(Month, Day,<br>May 20 | Year)<br>1947                       | 9. Birthplace (State or Foreign<br>Country)<br>Pennsylvania    |
|                | and   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City   | , Town or Lo                   | cation                                      |   |  |                                     | 10d. Inside City Limits  |
|                | Maryl<br>f sho  | ţo             | MD Prince George's Hya  | ttsvil                         | 1e  |   |  |                                     | 1 ∑Yes 2 No  |
|                | r 28a   | Director       | 10e. Street and Number  |                                | 10f. Zip Code                               |   | 1  | 0g. Citizen of W                    | /hat Country?  |
|                | th with   | al D           | 909 Continental Place   |                                | 20785                                       |   |  | USA                                 | A  |
|                | lams  | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?   | 3. 13. V                       | Was Decedent of Hi<br>f Yes, specify Cuba   | spanic Origin? (Span, Mexican, Puerto       | ecify Yes or No-<br>Rican, etc.)           |                                     | - American Indian,<br>k, White, etc.                           |
| 36             | s afte  | by Fu          | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☑ Divorced Year or Dates:   | 1                              | I ☐ Yes 2⊠ No                               | Specify:                                    |  | Specify:                            |  |
| 8              | e hour  |                | 15. Decedent's Education  | 16a. Decec                     | lent's Usual Occupa                         | ation                                       |  | 18b. Kind of Bu                     |  |
| 21215-0036     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or Itams 23a or 28a-f show<br>int, Ita Medical Examinar inteller multied at  | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  | (Give life. [                  | kind of work done of<br>OO NOT use retired, | luring most of worki<br>)                   | ing  |                                     | ,  |
|                | ad wit  | Com            | 4   | Equa1                          | Employee                                    |   |  |                                     | ruction  |
| Maryland       | be filk   | Be             | 17. Father's Name (First, Middle, Last)   |                                |   | 18. Mother's Name                           |  | Maiden Sumame                       | 9)   |
| 3              | hould<br>d Mer<br>marke   | ဍ              | Samuel Chivis  19a. Informant's Name/Relationship (Type, Print)   | 10h Mailie                     | g Address (Street a                         | Odessa 1                                    |  | City of Tour                        | State Tie Code)  |
| Ma             | d 2 s<br>th an<br>27 is r   |                | Martin Chivis/Brother   |                                | 6th Stree                                   |   |  |                                     |  |
|                | s 1 ar<br>f Hea<br>itam 3   |                | 20a Method of Disposition 20b. Pt   | ace of Dispos                  | sition (Name of natory or other place       |   |  |                                     | City or Town, State  |
| Ë              | Page<br>nert o<br>nt: tf  |                | Labural 2   Cremation 3   Hemoval nom State   |                                | emorial P                                   |   | 3,2005                                     | Landove                             | er, MD   |
| Baltimore,     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, the Medical Examination instituted at once. |                | 21. Signature of Funeral Service Licensee   |                                |   |   |  |                                     | DC 20011   |
|                |   |                | 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.               |                                |   |   |  |                                     | Approximate<br>Interval Between                                |
| 5              | Pnysician   | 8 1            | Immediate Cause (Final disease or condition   | +50                            | ~ VO  |   |  |                                     | Onset and Death  |
|                | /Medical  |                | resulting in death)  Due to (or as a consequ  | ence of):                      |   |   |  |                                     |  |
|                | Examiner  | L              | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequ   |                                |   |   |  |                                     |  |
| _              | ted<br>nsit   | niner          | cause. Enter Underlying   | ence of):                      |   |   |  |                                     |  |
|                | execun<br>n and<br>al-trar  | Examin         | that initiated events c   | ence of):                      |   |   |  |                                     |  |
| 8760,          | cate be executed<br>physician and<br>the burial-transit   | dicail         | d   |                                |   |   |  |                                     |  |
| Θ              | rtificat<br>ng phy<br>as th   | Medi           | IF FEMALE:  |                                |   |   |  |                                     |  |
| Вох            | To the Hospital or Attanding Physician: The law requires that the death certificate bythin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as          | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?   | death 3 🗌                      | Ectopic pregnancy<br>Other (specify)        |   |  | 23d. Date<br>Mon                    | e of delivery<br>ith Day Year                                  |
| o.             | the d<br>by the<br>ached  | ıysi           | 1 Yes 2 No 9 Unknown  |                                | ( otilor ( opcomy)                          |   |  |                                     |  |
| ď.             | s that<br>gned b  | by PI          | Part II. Other significant conditions contributing to death but not resu  | lting in the un                | nderlying cause give                        | n in Part I.                                | 23e. Did tob                               | acco use contri                     | bute to the cause of death?                                    |
| ğ              | w require<br>been sig<br>should b   | ted            | CHRONIC RENAL 'JAI  | LUR                            | -P , H                                      | TN  | 1 □ Ye                                     | s 2 🗆 No                            | 3 ☐ Probably 4 ☐ Unknown                                       |
| Vital Records, | law ri<br>las be  | Completed      |   |                                |   |   | 24a. Was ar<br>autops                      | y pi                                | /ere autopsy findings available rior to completion of cause of |
| <u></u>        | : The   | Co             |   |                                |   |   | perform                                    |                                     | eath?  Yes 25 No   |
| <u> </u>       | siclan<br>certifi<br>rector   | Be             | 25. Was case referred to medical examiner?  Hospital:   |                                | Othe  | 26. Place of Death                          |  |                                     | a tallition to   |
| o              | Physic ruthis aral di   | 5. T           | 27. Manner of Death 28a. Pate of Injury   | ER/Outpatient<br>28b. Time of  | t 3□ DOA Sure<br>28c. Injury<br>Work        | 4   Nursing nor                             | me 5 🗆 Reside<br>28d. Describe ho          |                                     |  |
| ion            | nding<br>th.<br>r: Afte<br>e fune   | atior          | 1 ☑Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation   | Injury                         |   | ?<br>(es 2 □ No                             |  |                                     |  |
| Division of    | r Atta<br>er deg<br>racto<br>by th  | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,  |                                | eet, factory, office                        | 12  | 28f. Location (Sti<br>City or Town         | reet and Numbe                      | r or Rural Route Number,                                       |
|                | ital o  |                | ,   |                                |   | 1   |  |                                     |  |
|                | To the Hospital or Attanding Physiclan: The lav<br>Within 24 hours after death.<br>To the Funeral Director: After this certificate has<br>completely filled in by the funeral director, page 2  | Medical        | 29a. Certifier 1 Certifying Physician: To the best of my know (Check only one) 2 Medical Examiner: On the basis of examinational manner stated. | rledge, death<br>on and/or inv | occurred at the tim<br>estigation, in my op | e, date and place, a<br>inion, death occurr | and due to the ca<br>ed at the time, da    | iuse(s) and mar<br>ate and place, a | nner as stated.<br>nd due to the cause(s)                      |
|                | ithin 2<br>tha<br>omple   | Med            | one) and manner stated.  29b. Signature and title of certifier  |                                | 29c. License                                | number                                      | 25   | 3d. Date signed                     | (Month, Day, Year)   |
|                | 1 5 F 8   |                | I Dem l   | W                              | 0-  | 3733  |  | -                                   | DER 4,200  |
|                | Goe   |                | 30. Name and address of person who completed cause of death (Item   | 23a) (Type, I                  | Print)                                      | 102115                                      |  |                                     | 11-5   |
|                | Sta   | to             | 31. Date filed (Month, Day, Year) 32. Redistrar's Stepan  | - j () /                       | 10,10.                                      | 17 611/                                     | ·  |                                     |  |
|                | Registr   |                | DEC 0 9 2005  |                                |   |   |  |                                     |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = For State Registrar Reg No U 0 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 0737 December 11 2005 Doris Ickes Coleman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death **Examiner** FASTON Memorial HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 □ X 217-28-1700 73 Yrs. August 18,1932 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a. State 10h County 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Queen Anne 1√Yes 2 No Maryland Centreville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 252 Beck Farm Rd. 21617 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fit ment of Health and Mental H tant: If item 27 is marked ot George Ickes Florence Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 252 Beck Farm Rd. Centreville, MD Sharon Coleman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or 4 □ Donation 15 □ Other (Specify) Metropolitan Crematory 12-15-05 Alexandria, Va 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licen de 6512 NW Crain Hwy Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** P855 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit MONOIN and resulting in death) Last Due to (or as a consequence of Box 68760, physicien Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☑No been signed by the a should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2√2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 14 Inpatient 1 ☐ Yes 2 🔯 No 2 ER/Outpatient 3 DOA After the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 ∰Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. investigation the f 2 Accident after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1/2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and Title of certifier

State Registrar

Olema

31. Date filed (Month, Day, Year)
DEC 1 2 2085

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Easton, MD 21601

Dr. Faith Matzoni

2+

|               |   |   |                             | riease  |  |                            |                                   |   | ik. Ensure A  | •                                  | _  |  |
|---------------|---|---|-----------------------------|---|--|----------------------------|-----------------------------------|---|---|------------------------------------|--|--|
|               |   |   |                             | for State   | State of Ma  | aryıan                     | •                                 |   | f Health and M                                      |                                    | 2000   | 10005  |
|               |   |   |                             | Registrar  1. Decedent's Name (First, Middle, L.  | - ont  |                            | Cen                               | ilicate c                                 | of Death  | 2. Date of Dea                     | Reg. No. UU                                    | 4.2.200  |
| _             |   | Physici<br>/Medic   |                             | Richard Gorg  | •  | 1                          |                                   |   |   | Month<br>December                  | Day . Year                                     | 3. Time of Death 5 1256 M                        |
|               |   | Examin  |                             | 4a. Facility Name (If not institution, gr   | - 1  | i                          |                                   | _ ^                                       | n, or Location of Death                             |                                    | 4c. County of Dea                              | 1  |
|               |   |   | *                           |   | Iospita  | · · · (12 1122             | In a high day                     | If Under 1 Ye                             | ear If Under 24 Hrs.                                | O Data of Dist                     | Talba  |  |
|               | 1.0   | Funeral<br>Director   |                             | 5. Social Security Number 6. 214–28–2756  | Sex 7. Ag  | Θ (In yrs.                 | 72 <sup>Yrs.</sup>                | Months Da                                 |   | 8. Date of Birti<br>(Month, Day    |  | thplace (State or Foreign ountry)                |
|               | 582   | liector.  | 23                          | Usual Residence of Decedent   |  |                            | 12                                |   |   | April 2                            | 2, 1933 Mt.                                    | Ranier, MD                                       |
|               | ylanc   | how   |                             | 10a. State 10b. County  |  |                            | y, Town or Loc                    |   |   |                                    |  | 10d. Inside City Limits                          |
|               | e Ma  |   | cto                         | Maryland Queen A  | Anne   |                            | Centrev                           | rille                                     |   |                                    |  | 1 ☐ Yes 2 ☐ No                                   |
| _             | đ th  | or 28   | Dire                        | 10e. Street and Number  |  |                            |                                   | 10f. Zip Cod                              |   |                                    | 10g. Citizen of What C                         | ountry?  |
| 5             | ath w   | 238   | ral                         | 102 Marshall Di   |  |                            |                                   |   | 21617   |                                    | USA  |  |
| 20            | er de   | E E   | une                         | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?                                  |                            | S. 13. W                          | as Decedent<br>Yes, specify (             | of Hispanic Origin? (Sp<br>Cuban, Mexican, Puerto   | ecity Yes or No-<br>Rican, etc.)   | 14. Race - Am<br>Black, Whi                    |  |
| 5             | 036<br>urs aft  | al', or iteme 23a or 28a-f show<br>Expedient mast be notified at                        | by Funeral Director         | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2√2<br>If Yes, Give<br>Year or Dates:                      | 140                        | 1                                 | ☐Yes 2☐X                                  | No Specify:   |                                    | Specify: W                                     | hite   |
| olemar        | 21215-0036<br>d within 72 hours after death with the Maryland   | natur   | Completed                   | 15. Decedent's E<br>(Specify only highest g   | Education<br>rade completed)                                       |                            | 16a. Decede                       | int's Usual Oc                            | cupation<br>one during most of work<br>tired)       | ing                                | 16b. Kind of Business                          | /Industry  |
| (7)           | 12 mg   | han.  | mpl                         | Elementary/Secondary (0-12)   | College (1-4or   | 5+)                        |                                   |   |   | i                                  |  |  |
| $\overline{}$ | CA BE   | d other the   |                             | 9th 17. Father's Name (First, Middle, Las   | st)  |                            | Aspha                             | alt/ Pa                                   | aving Co. O   |                                    | Private Maiden Sumame)                         |  |
| X             | E 23  | ag ag   | To Be                       | Albert Coleman  |  |                            |                                   |   |   | rude Koo                           |  |  |
| charc         | aryla<br>should   | I Health and Menitem 27 to marke  | -                           | 19a. Informant's Name/Relationship  | (Type, Print)  |                            | 19b. Mailing                      | Address (Str                              | eet and Number or Rura                              | a <i>i R</i> oute <i>Numb</i> e    | r, City or Town, State,                        | Zip Code)  |
| て             | Me and 2  | Health a  |                             | Sharon Coleman  | / Daughter   | r                          | 252                               | Beck I                                    | Tarm Rd. Cei  | ntrevill                           | Le, MD 216                                     | 17   |
| 7             | 2 5   | ā   |                             | 20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3   | ☐Removal from State  | 20b. P                     | lace of Dispos<br>emetery, crem   | ition (Name o<br>atory or other           | f<br>place)   | Date                               | 20c. Location - City or                        | Town, State                                      |
| 0             | ii m  | trant<br>tant:<br>jury c  |                             | 4 Donation 5 □ Other (Spec  | rify)  | Ft.                        | Lincol                            |   |   |                                    | 5 Brentwo                                      | od, MD   |
| CC            | Balt<br>permit.   | Department of Important: If any injury or once.   |                             | 21. Signature of Funeral Service Lice   | ensee  | as/                        |                                   |   |   |                                    | eral Home                                      |  |
| ( -           |   |   |                             | 23a Part 1 Enter the disease or co  | mplications that caused  | the deat                   |                                   | the mode of                               | Crain Hwy   |                                    | e, MD 2071                                     | 5<br>Approximate                                 |
|               |   |   |                             | 23a. Part1. Enter the disease, or conshock, or heart failure. List ont                                      | y one cause on each li   | ne.                        | 7 000                             | 000-60                                    | 4 6 6 6   | r rospiratory an                   |  | Interval Between<br>Onset and Death              |
|               |   | ysician<br>Jedical  |                             | disease or condition resulting in death)  | a<br>Due to (or as   |                            |                                   | 04000                                     | al pneum  | nonra                              |  |  |
|               | Ex  | aminer  |                             |   | · ·  | dico                       | ·                                 | est                                       | ggg, great  |                                    |  |  |
|               | T   |   | ner                         | Ecquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as  |                            |                                   |   |   |                                    |  |  |
|               | acute   | trans   | Examiner                    | Cause (Disease or injury that initiated events resulting in death) Last                                     | C  | rdia                       |                                   | Heni                                      | ia  |                                    |  |  |
|               | 760,  | sicien and<br>burial-transit  |                             | resulting in death) cast  | Due to (or as  | a conseq                   | uence of):                        |   |   |                                    |  |  |
|               | 87<br>cate  | attending physical for use as the b   | dical                       |   | d  |                            |                                   |   |   |                                    |  |  |
|               | Box 68  | ding<br>se as   | /Me                         | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome   | of pregna                  | incy                              |   |   |                                    | 23d. Date of de                                | livery   |
|               | Beath   | atter<br>d for u  | Iclar                       | in the past 12 months?  | 1□Live birth<br>4□Pregnant a                                       |                            |                                   | Ectopic pregna<br>Other (s <i>pecif</i> ) |   |                                    | Month  | Day Year   |
|               | O. at the   | ed by the<br>detached   | hys                         | 9 ☐ Unknown   | 9□ Unknown   |                            |                                   |   |   | -                                  |  |  |
|               | S, F  | igned<br>be de  | Completed by Physician/Medi | Part II. Other significant conditions  anoxic ence  | , -  |                            | ulting in the und                 | derlying cause                            | given in Part I.                                    |                                    | bacco use contribute to                        |  |
|               | <b>ord</b>  | been signe<br>should be   | eted                        |   | /  | 0                          |                                   |   |   | -                                  |  | robabły 4 🗖 Unknown                              |
|               | e aw  | has<br>39.2   | mple                        |   |  |                            |                                   |   |   | 24a. Was a<br>autop<br>perfor      | sy prior to                                    | utopsy findings available completion of cause of |
|               | al F  | certificate ha  |                             | OF Western street to see deal   |  |                            |                                   |   |   | 1 ☐ Yes                            | 2 No 1 ☐ Yes                                   | 2 □ No   |
|               | Vit   |   | o Be                        | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  | Hospital:  | ont 2                      | ER/Outpatient                     | 3□ DOA                                    | Other: 4 Thursing Ho                                |                                    | ne)<br>ence 6 ∐Other <i>(Spe</i>               |  |
|               | of<br>Phy   | n.<br>After this<br>funeral di  | n: To                       | 27. Manner of Death   | 28a. Date of Inju<br>(Month, Da                                    |                            | 28b. Time of                      |   |   |                                    | ow injury occurred                             | icity)   |
|               | ior   | oath.<br>or: Aft<br>oe fun  | atlo                        | 1-☑Natural 5 ☐ Pending<br>2 ☐ Accident investigate  | on   | ly (Gai)                   | Injury                            | м   | 1 ☐ Yes 2 ☐ No                                      |                                    |  |  |
|               | Division of Vital Records, P.O. Box 68760, Hospital or Atlanting Physician: The law requires that the death certificate be executed | efter de<br>I Directo<br>d in by th   | Certification:              | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   | 28e. Place of In<br>building, et                                   | jury - At ho<br>c. (Specif | ome, farm, stre                   | et, factory, off                          | ice   | 28f. Location (S<br>City or Tow    | treet and Number or R<br>n, State)             | ural Route Number,                               |
|               | Hospita   | within 24 hours efter death.  To the Funeral Director: A completely filled in by the fu | edical C                    | 29a. Certifier 1 Certifying F<br>(Check only 2 Medical Ex-  | Physician: To the best<br>aminer: On the basis of<br>and manner st | f examina                  | wledge, death<br>tion and/or inve | occurred at the                           | e time, date and place,<br>ny opinion, death occurr | and due to the cred at the time, c | ause(s) and manner a<br>date and place, and du | s stated.<br>e to the cause(s)                   |
|               | To the  | within<br>To the<br>compl   | Me                          | 29b. Signature and title of certifier   | _ /.   |                            |                                   | /   | ense number   | - 2                                | 29d. Date signed (Mon                          | h, Dey, Year)                                    |
|               |   |   |                             | I AL J.   | n 1  |                            |                                   |   | D55484  |                                    | 12-1   | 0-2005   |

Registrar

State

ORIGINAL

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Harou Jin 219 S Washington St. Easton , MD
31. Date filed (Month, Day, Year)

DEC 1 2 2005

2. Registrar's Signature

|                                |  | •               | 1 - For<br>State<br>Registrar   | State of Marylan   | -                      | artment of H   |   |   | giene                                     | 5 42266   |
|--------------------------------|--|-----------------|---|--|------------------------|--|---|---|---|---|
|                                | Physicia<br>/Medic   | 2.0             | 1. Decedent's Name (First, Middle, Last) ROBERT   | LEE  | CO                     | OPER   |   | 2. Date of De.<br>Month<br>DECEMI                 | BER 12,                                   | 3. Time of Death 2 0 0 5 1 2 : 1 0 pM   |
|                                | Examin   |                 | 4a. Facility Name (If not institution, give stre<br>6839 ED COURT   | eet and number)  |                        | 4b. City, Town, or   |   | h   | 4c. County o                              |   |
| 407                            | . Funeral<br>Director  |                 | 378-28-0838   | 7. Age (In yrs. 79   | last birthday)<br>Yrs. | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs<br>Hours Min.                       |   | 1 926                                     | 9. Birthplace (State or Foreign<br>Country)<br>NEW JERSEY                     |
|                                | f show   | oľ              | Usual Residence of Decedent  10a. State  10b. County  MD  CHARLES   | т.   | y, Town or Lo          |  |   |   |   | 10d. Inside City Limits   |
|                                | with the h<br>3s or 28a-   | i Director      | 10e. Street and Number<br>6839 ED COURT   |  | ND LIIN I              | 10f. Zip Code 2 0 6 4  | 40  |   | 10g. Citizen of WI                        | - ·   |
| 036                            | be filed within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural; or Items 23s or 28a-f show evant, the Medical Exameral in the could be a | by Funerai      | 11. Marital Status 12  1 Never Married 2 Married 3 Widowed 4 Divorced   | . Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:      | 1                      | Vas Decedent of H<br>f Yes, specify Cuba                         | ispanic Origin? (S<br>an, Mexican, Puer<br>Specify: | Specify Yes or No<br>to Rican, etc.)              | Black                                     | - American Indian,<br>, While, etc.<br>BLACK                                  |
| Baltimore, Maryland 21215-0036 | e filed within 72 hoi<br>al Hygiene.<br>I other than "natur:<br>vant, The Medical I  | Completed       | 15. Decedenl's Educa<br>(Specify only highest grade of<br>Elementary/Secondary (0-12)<br>12th   | tion<br>completed)<br>College (1-4or 5+)   | (Give                  | lent's Usual Occup<br>kind of work done of<br>DO NOT use retired | during most of wo<br>d)                             |   | 16b. Kind of Bus                          | DEPARTMENT  |
| and 2                          | ld be filed<br>ental Hygi<br>kad other<br>ic evant, I  | To Be Co        | 17. Father's Name (First, Middle, Last)   | RTHUR C  | OOPER                  |  |   | me (First, Middle,                                | Maiden Sumame<br>NEWMAN                   | )   |
| Mary                           | s 1 and 2 should be<br>f Health and Mental<br>itam 27 is markad o<br>othar traumatic eve   | -               | 19a. Informant's Name/Relationship (Type<br>MARY E. COOPER  |  |                        | g Address (Street<br>WHEELE                                      |   |   |   |   |
| imore,                         | permit. Pages 1 and 2<br>Department of Health<br>Important: If itam 27 i<br>any injury or othar tra  |                 | 20a. Nethod of Disposition  1 Burial 2 Cremation 3 Ren  4 Donation 5 Other (Specify)  | noval from State   | emetery, cren<br>URREC | sition (Name of<br>natory or other plac<br>TION CE               | M. 12-  | Date 19-2005                                      |   | ity or Town, Slate  |
| Balt Part                      | permit. Depart Import any inj  |                 | 21. Signatur of Funeral Service Connection  | uglos  | 1.7                    |  | H CAPI  | COL ST.   |   | SH.DC 20001   |
|                                | Physician  |                 | 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) | tions that caused the deat cause on each line.   | h. Do not ent          | 0  | g, such as cardia                                   |   | rrest,                                    | Approximate<br>Interval Between<br>Onset and Death                            |
| b                              | /Medical<br>Examiner   | _               | Sequentially list conditions, if any, leading to immediate  | Due to (or as a conseq   |                        |  |   |   |   |   |
| 8760,                          | icate be executed<br>physician and<br>s the burial-transit   | dical Examiner  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                      | Due to (or as a conseq   |                        |  |   |   |   |   |
| O. Box 687                     | death certif<br>s attending<br>d for use a   | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   | . If yes, outcome of pregna<br>1 □ Live birth 2 □ Feta<br>4 □ Pregnant at time of d<br>9 □ Unknown | I death 3              | Ectopic pregnancy Other (specify)                                |   |   | 23d. Date<br>Mont                         | of delivery<br>h Day Year   |
| rds, P.                        | og og  | by              | Part II. Other significant conditions contri  | buting to death but not res  | ulting in the u        | nderlying cause giv  | en in Part I.                                       |   | obacco use contrib<br>Yes 2 \( \sum No \) | oute to the cause of death?   |
| Il Records                     | The law<br>ate has b<br>page 2 st  | Completed       |   |  |                        |  |   |   | rmed? pr                                  | ere autopsy findings available for to completion of cause of lath?  Yes 2 XNo |
| f Vital                        | Physician: Th<br>this certificate<br>ral director, pag   | o Be            | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No   | spital:  | ER/Outpatien           | I 3 DOA Oth  |   | ath <i>(Check only o</i><br>Home 5 <b>∑</b> Resid | nne)<br>dence 6 ⊡Other                    | (Specify)   |
| ion of                         | ding<br>h.<br>After<br>fune  | ation: T        | 27. Menner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury | 28c. Injur<br>Wor  | y at  |   | now injury occurre                        |   |
| Division                       | al or Attanos after death  | Certification:  | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury - At h<br>building, etc. (Specif  |                        | eet, factory, office   |   | 28f. Location (S<br>City of Tox                   |   | r or Rural Route Number,  |
|                                | To the Hospital or Attanwithin 24 hours after deat To tha Funaral Diractor: completely filled in by the  | ledical (       |   | ian: To the best of my known:  To the basis of examination and manner stated.                      |                        |  |   |   |   |   |
| Ì                              | To the within 2 To tha complet   | M               | 29b. Signature and title of pertition   | bai  |                        | 29c. Licens  | e number<br>56050                                   |   | 29d. Date signed                          | (Month, Day, Year)  |
| )                              | (6)  | ate_            | 31. Date filed (Month, Day, Year)   | pleted cause of death (Item  | 1221                   | Print)   |   | Lone, 1   | argo, r                                   | D 20774   |
|                                | Registi  |                 | DEC 1 3 2005  | prince 16  | Ann                    |  |   |   |   |   |

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) DEC 2 0 2005

RICHARD ELLSWORTH DARNALL

Aegistrar's Signature

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Lest) 2 Dete of Death 3. Time of Death Month Year 30Am 000 Ph anie 10 05 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Lhahab (to Annapolis Nursty thoughouth Arme Ar If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Aug. 22, 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Days 1□ M 2**XX** Year 1960 Wash., DC 45 Aug. 577-86-4496 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 12 Yes 2 □ No Springdale Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20774 9011 Ardmore-Ardwick Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. **Black** Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Transcriber Private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ella Locke James Dickerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1407 Varnum St., N.W. Wash., DC 20011-7027 Calvin V. Dove - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 12/15/05 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 woo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE HUMAN IMMUNODEFICIENCY VIRUS (A105) vears Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 → No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner Examiner

as the burlel-transit

Physician/Medicai

þ

Completed

Be

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Certification:

Medicai

29a. Certifier

attending physician and

certificate

After this

Director:

in by the funeral

Hospital or Attending Physicien:

death.

efter

To the Hospital within 24 hours e To the Funeral C

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

**Physician** 

Examiner

**Funeral** 

Director

item 27 is marked other then "natural", or items 23s or 28e-f sho other traumatic event, the Modical Examiner must be notified at

a filed within 72 hours after di Il Hygiene. other then "natural", or item

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event

altimore, Maryland 21215-0020

death with the Marylend

/Medical

Directo

Funeral

2

Completed

Be

2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| 25. Was case referred to medical examiner? | W 2000    |                 |        | 26. Place of Death (C | heck only one) |                    |
|--|-----------|-----------------|--------|-----------------------|----------------|--------------------|
| 1 ☐ Yes 2 ☑ No                             | Hospital: | 2 ER/Outpatient | 3□ DOA | Other: 4 Nursing Home | 5 Residence    | 6 □Other (Specify) |

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

27. Manner of Death 1 Matural

5 Pending investigation 2 Accident 3 Suicide 6 Could not be determined 4 \( \text{Homicide} \)

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and clace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29b. Signature and title of certifier

29c. License number D01852

29d. Date signed (Month, Day, Year) DECEMBER 10, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4203 Queensbury Rd., Hyattsville, MD Paul A. DeVore, M.D.

State Registrar 31. Date filed (Month, Day, Year) BEC 1 5 2005



**DHMH 16 Rev 6/95** 

|                     |  |                | For State  | State of Ma  | ryland / Depa                       |   |  | ental Hygie                                | ne   | 10000  |
|---------------------|--|----------------|--|--|-------------------------------------|---|--|--|--|--|
|                     |  |                | Registrar  1. Decedent's Name (First, Middle, La.  | t)   | Cei                                 | rtificate of                                  | Death  | Reg.<br>2. Date of Death                   | No.  | 3. Time of Death                                   |
|                     | Physici  |                |  | ukes   |                                     |   |  | Month                                      | Day Year 2005                                  | 8:45 PM  |
|                     | /Medic<br>Examir   |                | 4a. Facility Name (If not institution, give  | street and number)   |                                     | 4b. City, Town, o                             | r Location of Death                                    |  | 4c. County of Death                            | 10.15  |
|                     |  |                | Caroline Home  | for Hosp   | oice                                | Denton  |  |  | Carolin  |  |
|                     | Funeral  |                | 5. Social Security Number 6. S   | 9X 7. Age<br>□M 2√⊋F   | (In yrs. last birthday)<br>7 1 Yrs. | If Under 1 Year<br>Months Days                | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth<br>(Month, Day, Yo        | 9. Birthi                                      | place (State or Foreign<br>ntry)                   |
|                     | Director   |                | 218-30-1624 Usual Residence of Decedent  | A  | / 1                                 |   |  | Sept.27,                                   | 1934 Mar                                       | yland  |
|                     | ryland   | _              | 10a. State 10b. County   |  | 10c. City, Town or Lo               | ecation                                       |  |  |  | 10d. Inside City Limits                            |
|                     | 8a-f   | Director       | MD Carol   | ine  |                                     | enton   |  |  |  | 1 Tes 2 No   |
|                     | with the   | Dire           | 10e. Street and Number   |  |                                     | 10f. Zip Code                                 |  |  | . Citizen of What Cou                          | •  |
|                     | leath<br>ns 23   | Funeral        | 7071 Federals  | Durg High  12. Was Decedent E  |                                     | 216   |  |  | ited Sta                                       |  |
| Maryland 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland<br>Health and Mental Hygiene.<br>Item 27 Ie marked other then "naturel", or Items 23a or 28a-f show<br>other traumatic event, the Medical Examinar must be notified at | by             | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:                         | 0                                   | lf Yes, specify Cuba<br>1 ☐ Yes 21② No        | dispanic Origin? (Spean, Mexican, Puerto P<br>Specify: | lican, etc.)                               | Black, White.                                  |  |
| 5-0                 | 72 ho  | etec           | 15. Decedent's Ed<br>(Specify only highest gra   | ucation<br>de completed)   | 16a. Dece                           | dent's Usual Occup                            | pation<br>during most of workin<br>d)                  | g 16i                                      | b. Kind of Business/In                         | dustry   |
| 121                 | within<br>ene.<br>then   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+  |                                     | DONOTuse retired<br>UC <b>ti</b> on           |  | S  | isk Fulf                                       | illment  |
| <b>d</b> 2          | filed<br>Hygie<br>other  |                | 17. Father's Name (First, Middle, Last)  |  | 1100                                | decion  | 18. Mother's Name                                      |  |  |  |
| lan                 | ould be<br>Mental<br>larked o  | To Be          | William Wells  |  |                                     |   | Frances  |  |  |  |
| ary                 | 2 should be filed withir and Mental Hygisne. Is marked other then sumatic event, the Ma  | -              | 19a. Informant's Name/Relationship (7  | ype, Print)  | 19b. Mailir                         | ng Address (Street                            |  |  | ity or Town, State, Zip                        | Code)  |
|                     | 1 and 2<br>Health<br>am 27 I   |                | Cortland V. Dul  | ces/Son  | 7351                                | Todd's  | Wharf R  |  | ston, MD                                       |  |
| Baltimore,          | 00   |                | 20a. Method of Disposition  1 A Burial 2 Cremation 3 C   | Removal from State   |                                     | natory or other place                         | ce)  |  | . Location - City or To                        |  |
| Ħ                   |  |                | 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen   |  | Concord                             |   |  |  | deralsbu                                       |  |
| Ba                  | permit. Depertrimports eny inju  |                | Michael 7.   | Estrow   | 2                                   | 16 N. M.                                      | ain St.,   | Federa                                     | lsburg,  | ome, P.A.<br>MD 21632                              |
|                     | Physician<br>/Medical  |                | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | El Wan   |                                     |   | eg, such as cardiac or                                 |  | iers   | Approximate<br>Interval Between<br>Onset and Death |
|                     | Examiner   |                | Sequentially list conditions.  | b  |                                     |   |  |  |  |  |
|                     | ed sit   | ulne           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                    | Due to (or as a  | consequence of):                    |   |  |  |  |  |
|                     | fficate be executed<br>physicien and<br>is the burial-transit  | Examiner       | that initiated events<br>resulting in death) Last  | c<br>Due to (or as a   | consequence of):                    |   |  |  |  |  |
| 68760,              | ysicial  | edicati        |  | d  |                                     |   |  |  |  |  |
|                     | = O a  |                | IF FEMALE:   |  |                                     |   |  |  |  |  |
| P.O. Box            | The law requires thet the death certif<br>ste has been signed by the ettending<br>page 2 should be detached for use as   | Physician/M    | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown   | 23c. If yes, outcome of<br>1 □ Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown | Fetal death 3                       | Ectopic pregnancy<br>Other (specify)          |  |  | 23d. Date of delive<br>Month                   | ery<br>Day Year                                    |
| of Vital Records, P | uires thet<br>signed b<br>Id be deta   | ρ              | Part II. Other significant conditions of   | entributing to death but   | not resulting in the ur             | nderlying cause give                          | en in Part I.  |  | co use contribute to the                       |  |
| COI                 | law requas been 2 shoul  | Completed      |  |  |                                     |   |  | 24a. Was an                                | 24b. Were auto                                 | psy findings available                             |
| A.                  | The la   | mo             |  |  |                                     |   |  | autopsy<br>performed                       | prior to con<br>death?                         | mpletion of cause of                               |
| /ita                | certifice<br>rector, p   | Be             | 25. Was case referred to medical examiner?   |  |                                     |   | 26. Place of Death                                     |  |  | ( )  |
| of \                | Physi<br>this c  | 2              | 1 Yes 2 No   |  | 2 ER/Outpatien                      |   | 4 🗆 Nursing Hom  | e 5 Residence                              |  | blospice   |
|                     | ding h.<br>h.<br>After<br>funer  | tlon           | 1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day   | Year) 28b. Time of Injury           | Worl  | yat 2≀<br>k?<br>Yes 2 □ No                             | 3d. Describe how i                         | njury occurred                                 | horece   |
| Division            | Attendi<br>r death.<br>ector: A<br>by the fu   | lfica          | 3 Suicide 6 Could not be   | 28e. Place of Injury   | y - At home, farm, stre             |   |  | of. Location (Stree                        | t and Number or Rura                           | I Route Number,                                    |
| ă                   | s after<br>s after<br>al Dire<br>ed in by  | Certification: | 4 Homicide determined  | building, etc.   | (Specify)                           |   |  | City or Town, S                            | tate)  |  |
|                     | To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  | edlcal         | 29a. Certifier (Check only one)  2 Medical Exam  | rsician: To the best of<br>iner: On the basis of e<br>and manner state           | xamination and/or inv               | occurred at the time<br>restigation, in my op | ne, date and place, ar<br>pinion, death occurred       | nd due to the cause<br>d at the time, date | e(s) and manner as st<br>and place, and due to | ated. the cause(s)                                 |
|                     | To the within 2 To the complet   | Σ              | 29b. Signature and title of certifier  | >  |                                     | 29c License                                   | e number   | 29d.                                       | Date signed (Month,                            |  |
|                     |  |                | 1 1 Wed Ad   | ww   |                                     | 103   | 1881   |  | 12   19   05                                   | )  |
|                     |  |                | 30. Name and address of person who o<br>David H. Smit  |  |                                     |   | Dr., Eas   | tor MT                                     | 21401  |  |
|                     | Sta  | te             | 31. Date filed (Month, Day, Year)  | 32. Registrar  | 's Signature                        | -11 - 11 - 11                                 | rio, Eas   | COH, MD                                    | 21601  |  |
|                     | Registr  |                | DEC 2 0  | 2005   | John St. A                          | Goods.  |  |  |  |  |

|  |                | Please 1  | Type or Print in  | Black I                       | ndelible   | e Ink.                  | Ensure A                             | All Copies                              | Are                    | Legible.                        |   |                                       |
|--|----------------|---|---|-------------------------------|--|-------------------------|--------------------------------------|---|------------------------|---------------------------------|---|---------------------------------------|
|  |                | 1 - For<br>State<br>Registrar   | State of Maryla   |                               | partmen<br><i>ertificat</i>                              |                         |                                      | Mental Hy                               | giene                  |                                 | 100   | 70                                    |
| A. P. W  | e e            | Registrar  1. Decedent's Name (First, Middle, Last  | )   |                               | ertilicat  | e or L                  | Jealii                               | 2. Date of De                           | Reg. No<br>aath        | 2000                            | 3. Time of D                                    | Death                                 |
| Physicia<br>/Medic   |                | PEARL E. DL   | UZNIEWS   | KI                            |  |                         |                                      | Decemb                                  | Pa                     | 18 2005                         | 0630  | ) M                                   |
| Examin   |                | 4a. Facility Name (If not institution, give Memorial Hospi  | street and number)  |                               | A  | Town, or                | Location of Dea                      | th                                      | 4c                     | County of Deal                  |   |                                       |
| Funeral<br>Director  | 98             | 133 03 0117   | x 7. Age (In yrs  | s. last birthda<br>Yrs.       | Months   | 1 Year<br>Days          | If Under 24 Hrs<br>Hours Min         |   | th<br>19191            | 7 Phil                          | hplace (State or<br>untry)<br>adelph            | Foreign<br>is I                       |
| ith the Maryland<br>or 28a-f show  | tor            | Usual Residence of Decedent  10a. State  Md  10b. County  Talbot  |   | city, Town or                 | Location<br>Chaels                                       | 5                       |                                      |   |                        |                                 | 10d. Inside City                                |                                       |
| death with the Maryland<br>ime 23a or 28a-f show   | ai Director    | 10e. Street and Number<br>1103 Harrison   | Ave. P.O. E   | 30x 5                         | 73 10f. Zip  | 1663                    |                                      |   | 10g. Cit               | izen of What Co<br>USA          | untry?  |                                       |
| ter deal   | Funerai        | 11. Marital Status  | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No                                   | U.S. 1:                       | 3. Was Deced   | dent of His             | spanic Origin? (:<br>n, Mexican, Pue | Specify Yes or Norto Rican, etc.)       | )-                     | 14. Race - Ame<br>Black, Whit   |   | · · · · · · · · · · · · · · · · · · · |
| 72 hours afte<br>"natural", or I   | þ              | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:  |                               | 1 ☐ Yes  |                         | Specify:                             |   |                        | Specify: Wh                     |   |                                       |
| within 72 hours after<br>lene.<br>then "natural", or its   | Completed      | 15. Decedent's Edu<br>(Specify only highest grad  |   | (Gi                           | cedent's Usua<br>ive kind of wo<br>b. DO NOT us<br>ancer | rk done d               | uring most of wo                     | orking                                  |                        | ind of Business/<br>ntertai     | ,   |                                       |
| permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatic event, ITEM ORGE. | To Be C        | 12 years 17. Father's Name (First, Middle, Last) Rene Leaf  |   |                               |  |                         |                                      | me (First, Middle<br>ma Wigi            |                        |                                 |   |                                       |
| 2 shou<br>and N<br>Is man  |                | 19a. Informant's Name/Relationship (T)  |   |                               |  |                         |                                      | ural Route Numb                         |                        |                                 |   |                                       |
| 1 and 1 health mm 27 ther tr   |                | Donna Lee Cole 20a. Method of Disposition   |   | i                             | BOX  |                         | , St.                                | Michael<br>Date                         |                        |                                 |   |                                       |
| Pages<br>tment of h<br>tant: If its<br>jury or of  |                | 1 ☐ Burial 2 🎇 Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  | Removal from State Ca   | cemetery, c<br>apito          | rematory or o  | matc                    | ory 12-                              | -19-200                                 | 5 I                    | Dover,                          | De.   |                                       |
| permit<br>Depert<br>Import<br>eny in   |                | 21. Signature of Funeral Service Licens   | 88  |                               | R . Ca   | rro]                    | of Facility<br>Hur]                  | Ley Fun                                 | era                    | l Home                          | , PC  |                                       |
|  |                | 23a. Part1. Enter the disease, or comb shock, or heart failure. List only o   | ications that caused the dec  | ath. Do not e                 | Res (Re mod  | BOX                     | , Sich & carde                       | t respiratory                           | hae:                   | ls, Md                          | Approximate<br>Interval Between                 | 3                                     |
| Physician<br>/Medical<br>Examiner  |                | Immediate Cause (Final disease or condition resulting in death)   |   |                               |  |                         |                                      | ral he                                  |                        |                                 | Onset and De                                    | y S                                   |
| xecuted<br>and<br>I-transit  | caminer        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conse   | equence of):                  |  |                         |                                      |   |                        |                                 |   |                                       |
| icate be exer<br>physician ar<br>s the burial-t  | ledicai Ex     | resulting in death) Last  | Due to (or as a conse   | equence of):                  |  |                         |                                      |   |                        |                                 |   |                                       |
| ne death certif<br>the attending<br>thed for use as  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | 23c. If yes, outcome of preg<br>1 Live birth 2 Fe<br>4 Pregnant at time of<br>9 Unknown | tal death                     | 3 □Ectopic pr<br>5 □ Other (sp                           |                         |                                      |   |                        | 23d. Date of del<br>Month       | very<br>Day Ye                                  | ar                                    |
| es that the igned by be detact   | by Ph          | Part II. Other significant conditions co  | ntributing to death but not re  | sulting in the                | underlying c   | ause give               | n in Part I.                         | 23e. Did 1                              | obacco (               | use contribute to               | the cause of dea                                | ath?                                  |
| w require<br>been sig<br>should b  |                | Dyshpiden   | ua  |                               |  |                         |                                      | 10                                      | Yes 2                  | No 3□Pr                         | obably 4 🗆 Un                                   | known                                 |
|  | Completed      | <u> </u>  |   |                               |  |                         | <u> </u>                             | 24a. Was<br>auto<br>perfo<br>1 ☐ Yes    |                        | prior to death?                 | topsy findings av<br>completion of cau<br>2  No | allable<br>use of                     |
| ician: Th<br>certificete<br>rector, pag  | Be             | 25. Was case referred to medical examiner?  | Hospital:   |                               |  | Otho                    | -                                    | ath (Check only                         |                        |                                 |   |                                       |
| hys<br>aldi  | n: To          | 27. Manner of Death   | 28a. Date of Injury   | ER/Outpat<br>28b. Time        |  | 8c. Injury<br>Work      | 4 🗀 Nursing I                        | Home 5 ☐ Resi<br>28d. Describe          |                        |                                 | eify)   |                                       |
| endin<br>eath.<br>or: Aft  | atio           | 1 Natural 5 Pending 2 Accident Investigation  | (Month, Day Year)   | Injur                         | М  |                         | es 2□No                              |   |                        |                                 |   |                                       |
| in Digita  | Certification; | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - At<br>building, etc. (Spec                                       | home, farm,<br>cify)          | street, factory  | , office                |                                      | 28f. Location (<br>City or To           | Street an<br>wn, State | nd Number or Ru<br>))           | ral Route Numbe                                 | er,                                   |
| o the Hospital   | edical         | 29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami  | sician: To the best of my kr<br>ner: On the basis of examinand manner stated.           | nowledge, de<br>nation and/or | ath occurred investigation                               | at the tim,<br>in my op | e, date and plac<br>inion, death occ | e, and due to the<br>urred at the time, | cause(s)<br>date and   | and manner as<br>place, and due | stated.<br>to the cause(s)                      |                                       |
| ro the<br>within of  | Mec            | 29b. Signature and title of certifier   | and manner stated.  |                               | 290  | . License               | number                               |   | 29d. Dat               | te signed (Monti                | o, Day, Year)                                   |                                       |
|  |                | D. Olayon   | ni Ms   |                               | 1  | 143                     | 261                                  |   | 12                     | /18/2                           | 005   |                                       |
| (10)   |                | 30. Name and address of person who co   | ompleted cause of death (Ite  Memorisal   | HOOM                          | ital,  | 219                     | S. Was                               | hington                                 | Stre                   | et, East                        | N, MD<br>216                                    | 01                                    |
| Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) DEC 2 0 200   | 32. Registrar's Sign  |                               | to the   |                         |                                      |   |                        |                                 |   |                                       |

DHMH 17 Rev 1/2001

Reg. No.

State Registrar Amend #18 per/fh 12-21-2005 Centificate of Death

DHMH 17 Rev 1/2001

State

Registrar

Joanne L. Kinney M.D.

2005 ▶

31. Date filed (Month, Day, Year)

32. Registre's Signature

9701 New Church Street, Damascus, Maryland

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician William Patrick DeCourcy, Sr. 2005 December 12. 4:15 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F Yrs. 164-22-9335 76 Director March 8, 1929 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show rthan "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4707 Mercury Drive 20853 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1951-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within that and Mentel Hygiene.
7 is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Special Agent Federal Government permit. Peges 1 and 2 should be filed v Department of Health and Mentel Hygie Umportant: If item 27 is marked other t any injury or other treumatic event, itt pnce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael S. DeCourcy Nora Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne P. DeCourcy/ Wife 4707 Mercury Drive, Rockville, MD 20853 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 € Burial 2 Cremation 3 Removal from State December 16, Cate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2005 Silver Spring, Maryland 21. Signature I Funeral Service Licensee Francis Address Corins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 12 Years Immediate Cause (Final disease or condition resulting in death) **Physician** Dilated Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) burial-transit certificate be executed Exami and Due to (or as a consequence of) anding physicien a use as the burial-Box 68760, Physician/Medical d IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ď cate has been signated bage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has Division of Vital 1 ☐ Yes 2 X No a Hospitat or Attanding Physician: T 24 hours after deeth. a Funeral Diractor: After this certificat etely filled in by the funeral director, px 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 3□ DOA 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitat within 24 hours a To the Funeral E 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) cany D0052069 12-13-05 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10313 Georgia suite 307, Silver Spring MD 20902 Knry Ave, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 15 2005 Registrar

UNK 05-08361 RKD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Brian Daigle Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** DECEMBER 11, 2005 PAUL DAIGLE 6:00A BRIAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON 22 MOUNTAIN ROAD KEEDYSVILLE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑**M 2□F Yrs. 632-09-2818 TEXAS 30, Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a, State 10b County or 28a-f ahow rthan "natural", or Itama 23a or 28a-f ahov the Medical Exerciser must be mutified at 1XYes 2 No BOONSBORO MARYLAND WASHINGTON Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21713 U.S.A. 16 CHESTNUT AVENUE death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 M No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritaf Status Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Efementary/Secondary (0-12) College (1-4or 5+) i Hygiene. other then 12 STUDENI COLLEGE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F 27 is marked of traumatic avail Karla Jan Wynn Paul David Daigle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: 9 Department of Health ar important: if Item 27 is any injury or other traugure. KARLA J. LITTLE/MOTHER 16 CHESTNUT AVENUE, BOONSBORO, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State SMITHSBURG CREMATORY | 12/17/05 4 Dogatto 5 ☐ Other (Specify) SMITHSBURG, MARYLAND 21. Signature of Full 22. Name and Address of Facility 7606 Old National Pike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Smoke and scot inhalation and thermal injuries /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Attanding Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical the e IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ned by the ettend a detached for us 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify SCENE Hospitaf: 1X Yes 2 □ No 1 Inpatient 2 EN/Outpatient 3 DOA nours effer death.

neral Director: After this this 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury 1 | Natural 5 Pending investigation 5:15 AM 1 ☐ Yes 2 🗷 No house tre 11,2005 Dec 2 Accident 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 22 Montan Coad, Keedys Ville, MD 3 Suicide determined 4 Homicide Louse within 24 hours e To the Funeral L i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Laishe 4 O.C.M.E. DECEMBER 12,2005 ND 30. Name and address of person who completed sauce of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 17-4 Orienbero M.D dstra 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Call and DEC 19

Registrar

| 1   | 1                | _ State  | State of Maryland / Dep<br>Co   | partment of Health and<br>ertificate of Death   |   | ene<br>1.No. 2005 1.2275  |
|---|------------------|--|---|---|---|---|
|   |                  | Registrar  1. Decedent's Name (First, Middle, Last)                              |   |   | 2. Date of Death<br>Month                           | Day Year 1 200  |
| Physicia  | an               | JoAnn R. Dost  | er  |   | December  | 16 2005 1029 M  |
| /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give str                                  | reet and number)  | 4b. City, Town, or Location of De   | ath   | 4c. County of Death   |
|   |                  | 1718 Wood Tree Ci  |   | Annapolis  If Under 1 Year   If Under 24 H  | re O Data of Birth                                  | Anne Arundel  |
| Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 1□1   | 7. Age (In yrs. last birthda<br>Yrs.  | Months Days Hours Mi  |   | 9. Birthplace (State or Foreign Country) Minnesota                      |
| and<br>w  |                  | Usual Residence of Decedent  10a. State 10b. County                              | 10c. City, Town or  | Location  |   | 10d. Inside City Limits   |
| Maryl   | ğ                | Maryland Anne Arun   | del Annapol   | is  |   | 1 □Yes 2 No   |
| r 28e   | rec              | 10e. Street and Number   |   | 10f. Zip Code   | 10  | g. Citizen of What Country? USA   |
| 23a c   | a D              | 1718 Wood Tree Cir   |   | 21401   | (Specify Vas or No-                                 | 14. Race - American Indian,   |
| er dee  | Funeral Director | 11. Marital Status 1 □ Never Married 2 ☒ Married                                 | 2. Was Decedent Ever in U.S. 1 Armed Forces? 1 ☐ Yes 2 Ø No                   | Was Decedent of Hispanic Origin?     ff Yes, specify Cuban, Mexican, Pu                       | erto Rican, etc.)                                   | Bfack, White, etc.  |
| ING X IX I 3-0030<br>be filed within 72 hours after deeth with the Maryland<br>la! Hyglene.<br>d other then "nature!, or items 23a or 28e-f ehow<br>event, the Medical Exactina must be notilised at  | à                | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:  | 1 ☐ Yes 2 ☒ No Specify:   |   | Specify: White  |
| 2-UU3<br>72 hours a<br>naturel', o  | Completed        | 15. Decedent's Education (Specify only highest grade                             | completed) (G   | cedent's Usual Occupation<br>ive kind of work done during most of v<br>e. DO NOT use retired) |   | 6b, Kind of Business/Industry 4   |
| within she.   | du               | Elementary/Secondary (0-12)  | College (1-4or 5+)  | nting Finisher  |   | Printing  |
| Hygie other   | Be Co            | 17. Father's Name (First, Middle, Last)  |   |   | Name (First, Middle, M                              | aiden Sumame)   |
| Z should be to and Mental is marked o   | To B             | unknown  | Risburg   |   | Unknown   |   |
| Maryland ZIZI: id 2 should be filed within " ith and Mental Hygiene. 27 is marked other then " reaumatic event, the Mes   |                  | 19a. Informant's Name/Relationship (Typ  |   | ailing Address (Street and Number or<br>. Andrews Rd., Set                                    | Rural Route Number,<br>verna Park                   | City or Town, State, Zip Code) , MD 21146                               |
| 1 end<br>1 end<br>Health<br>em 27   |                  | 20a. Method of Disposition   | 20b. Place of Di  | sposition (Name of crematory or other place)  | Date 2  | Oc. Location - City or Town, State                                      |
| mor   |                  | 1 ☐ Burial 2X Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)               |   | Crematory 12.   |   | Edgewater, MD   |
| Baltimore, Marylar permit. Pages 1 end 2 should by Oppertment of Health and Menta Importent: if Item 27 is marked eny Injury or other traumatic en 2008.  |                  | 21. Signature 1 Junya Service License  | е   | 22. Name and Address of Facility (2973 Solomons Is.   | George P. I<br>land Rd. E                           | Kalas Funeral Home<br>dgewater, MD 21037                                |
|   |                  | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on | cations that caused the death. Do not   | enter the mode of dying, such as care   | diac or respiratory arre                            | st, Approximate Interval Between Onset and Death                        |
| Physician   |                  | fmmediate Cause (Final disease or condition                                      | Thatquh wo  | to heed   |   | Onset and Death   |
| /Medical<br>Examiner  |                  | resulting in death)  | Due to (or as a consequence of):  |   |   |   |
| - Adminion  | - G              | Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying | Due to (or as a consequence of):  | :   |   |   |
| d d ansit   | Examiner         | that initiated events  |   |   |   |   |
| 8760, rate be executed hysicien end the burial-transit  | Exa              | resulting in death) Last   | Due to (or as a consequence of):  |   |   |   |
| 8760,<br>cate be ex<br>cate be ex<br>chysicien<br>the burial  | dicai            |  |   |   |   |   |
| Box 687 death certificate e attending phys of for use as the  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant 2:   | 3c. If yes, outcome of pregnancy  | 205-1   |   | 23d. Date of delivery   |
| Geath death e atter   | Iclar            | in the past 12 months? 1 ☐ Yes 2 ☐ No  | 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown      | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   |   | Month Day Year  |
| P.O.  | Phys             | 9 ☐ Unknown  Part fl. Other significant conditions con                           |   | ne underlying cause given in Part I.  | 23e. Did tob  | acco use contribute to the cause of death?                              |
|   | b V              | Part II. Other significant conditions con  | imbuting to death but not resulting in the                                    | to uniquity ing out too given any time  | 1 □ Y6  | s a No 3 Probably 4 Unknown   |
| Records, The law requires to the best been signed age 2 should be to be | Completed        |  |   |   | 24a. Was a  | 24b. Were autopsy findings available                                    |
| E 2 2 8   | d Ho             |  |   |   | autops  | ned? death?   |
| _ 6 6.  | BeC              | 25. Was case referred to medical examiner?                                       |   |   | Death (Check only on                                |   |
| vision of Vital Attending Physicien: r death. •ctor: After this certific by the funeral director.   | 10               | 1□ Yes 2□ No   |   |   |   | once 6XXX ther (Specify) Scene  |
| ding P. Alter I   | lon              | 27. Manner of Death  1 Natural 5 Pending investigation                           | (Month, Day Year) Inj   |   | Sibir   | et in abot  |
| Division Il or Attending eller deeth. I Director: Alte  | fleat            | 3 Suicide 6 Could not be   | 28e. Place of Injury - At home, farm  | n, street, factory, office  | 28f. Location (St<br>City or Town                   | reet and Number or Rural Route Number,                                  |
| Oiv selfer  | Certification:   | 4 Chomicide  | building, etc. (Specify)  |   | 1718 00   | of Tree Cule Anapolismo   |
| Divisic<br>To the Hospital or Attence<br>within 24 hours after deet<br>To the Funeral Director:<br>completely filled in by the  | edical (         | (Check only 2. Medical Exami   | sician: To the best of my knowledge,<br>ner: On the basis of examination and/ | death occurred at the time, date and p<br>for investigation, in my opinion, death             | place, and due to the co<br>occurred at the time, d | ause(s) and manner as stated.<br>ate and place, and due to the cause(s) |
| thin 24   | Med              | 29b. Signature and title of certifier  | and manner stated.  | 29c. License number   |   | 9d. Date signed (Month, Day, Year)                                      |
| 5 1 <u>8</u> 5  | -                | Annade   | e NA  | OCME  |   | December, 17, 2005  |
| . /   |                  | 30. Name and address of person who co  | ompleted cause of death (Item 23a) (T   | ype, Print)   |   |   |
| 5   |                  | Taska Z Green be   |   |   | reet Balti  | more, Maryland 21201  |
| S<br>Regis  | tate             | 31. Date filed (Month, Day, Year) DEC 3 0 21                                     | 32. Jegistrar's Signature   | Sporte  |   |   |

Lanny Richard Doster 05-08502 NJM

| 8502                  | Ple                               | ease Type or              | Print in Black In-             | delible Ink.       | Ensure A          | II Copies A      | re Leg   | jible.      |                    |
|-----------------------|-----------------------------------|---------------------------|--------------------------------|--------------------|-------------------|------------------|----------|-------------|--------------------|
|                       | For                               | State of                  | of Maryland / Depa             | artment of H       | ealth and M       | lental Hygie     | ene n    | 05          | 1.227              |
|                       | 1 - For<br>State<br>Registrar     |                           | Cei                            | tificate of l      | Death             | Reg              | . No.    | 0.0         | tray have have I   |
|                       | 1. Decedent's Name (First, Mi     | ddle, Last)               |                                |                    |                   | 2. Date of Death |          |             | 3. Time of Deat    |
| Physician<br>/Medical | Lanny Rich                        | ard Doster                | •                              |                    |                   | December         | I6       | 2005        | 1029               |
| Examiner              | 4a. Facility Name (If not institu | ition, give street and nu | umber)                         | 4b. City, Town, or | Location of Death |                  | 4c. Coun | ty of Death |                    |
|                       | 1718 Wood                         | Tree Circl                | e                              | Annapol:           | is                |                  | Anne     | Arund       | e1                 |
| Funeral               | 5. Social Security Number         | 6. Sex                    | 7. Age (In yrs. last birthday) | If Under 1 Year    | If Under 24 Hrs.  | 8. Date of Birth |          |             | lace (State or For |

|                            | /Medic   | al               | Lanny  | Richard                               | Doster            |                        |  |            |                           |                     |           |              | pecembe                             | =r       | 10        | 2005           | 1029   |
|----------------------------|--|------------------|--|---------------------------------------|-------------------|------------------------|--|------------|---------------------------|---------------------|-----------|--------------|-------------------------------------|----------|-----------|----------------|--|
|                            | Examin   | er               | 4a. Facility Name (If  | not institution, giv                  | e street and nu   | ımber)                 |  |            | 4b. City,                 | Town, or            | Location  | of Death     |                                     | 4        | c. Count  | y of Death     |  |
|                            |  |                  | 1718 1   | Wood Tree                             | Circ1             | _                      |  |            | Ann                       | apol:               | ic        |              |                                     | ٨        | mno       | ل A            | -1   |
|                            | Francis I  |                  | 5. Social Security No  |                                       |                   |                        | (In yrs. last bir  | thday)     |                           | r 1 Year            | If Unde   | or 24 Hrs.   | 8 Date of Bi                        | rth P    | ше        | Arund          | e L<br>lace (State or Foreign                  |
|                            | Funeral  |                  |  |                                       | ZM 2□ F           |                        |  | Yrs.       | Months                    | Days                | Hours     |              | 8. Date of Bi<br>(Month, D<br>11-10 | ay Yea   | 7)_       | Coun           | try)   |
|                            | Director   |                  | 258-72-4   | 140                                   |                   | 59                     |  | 113.       |                           |                     |           |              | 11-10                               | -194     | 16        | Geo:           | rgia   |
|                            | p  |                  | Usual Residence of   |                                       |                   |                        |  |            |                           |                     |           |              |                                     |          |           |                |  |
|                            | ylar<br>M  |                  | 10a. State   | 10b. County                           |                   |                        | 10c. City, Tow   |            |                           |                     |           |              |                                     |          |           | 10             | 0d. Inside City Limits                         |
|                            | War War  | Ö                | Maryland   | Anne Ar                               | undel             |                        | Anna   | apo]       | lis                       |                     |           |              |                                     |          |           | i              | 1 ☐ Yes 2 No                                   |
|                            | 28 p   | C                | 10e. Street and Num  |                                       |                   |                        |  |            | 404 7                     | 0.4                 |           |              |                                     | 40.0     |           | 100            |  |
|                            | € 9  | 급                |  |                                       |                   |                        |  |            | 10f. Zip                  |                     |           |              |                                     | iug. C   | Juzen of  | What Coun      | try?   |
|                            | 23e  | <u>a</u>         | 1718 Wood  | d Tree C                              | ircle             |                        |  |            |                           | 2140                | 1         |              |                                     |          | USA       | A.             |  |
|                            | e  | Funeral Director | 11. Marital Status   |                                       | 12. Was Dec       | edent Ev               | er in U.S.   | 13. \      | Nas Dece                  | dent of H           | spanic C  | rigin? (Spe  | ecify Yes or N<br>Rican, etc.)      | 0-       |           | ce - America   |  |
| 10                         | à 5  | Ξ                | 1 Never Marrie   | ed 2 Married                          | Armed F           |                        | )  |            | r res, spe                | слу Сира            | n, Mexic  | an, Puerto   | Rican, etc.)                        |          | Bla       | ck, White,     | etc.   |
| 8                          | rs a   | by               | 3 ☑ Widowed  | 4 □ Divorced                          | If Yes, G         | 2 No                   | LetNam   | 1          | 1 🗌 Yes                   | 2 <b>X</b> No       | Specif    | y:           |                                     |          | Specil    | y: Whi         | .te .  |
| Ö                          | hou si   | D                | 71   |                                       |                   |                        |  | 0          |                           |                     |           |              | -                                   | 1        |           |                |  |
| 21215-0036                 | within 72 hours after death with the Maryland<br>ane.<br>then "naturel", or iteme 23e or 28e-f ehow<br>the Medical Examiner must be notified at  | Completed        | (Speci   | 15. Decedent's Enity only highest gra | de completed,     | )                      | 168.   | (Give      | lent's Usua<br>kind of wo | rk done d           | turina mo | st of worki  | ing                                 | 16b.     | Kind of B | Business/Ind   | dustry   |
| 7                          | the state  | ď                | Elementary/Secon   | ndary (0-12)                          | College           | 1-4or 5+               | )  | life. L    | DO NOT u                  | se retired          | )         |              |                                     |          |           |                |  |
| 21                         | gier d'y   | ŏ                | 12th   |                                       |                   |                        |  | Ba         | arten                     | der .               |           |              |                                     |          | Hosp      | oitali         | .ty  |
| Q                          | a the first  | Be (             | 17. Father's Name (  | First, Middle, Last,                  |                   |                        |  |            |                           |                     | 18. Mot   | her's Name   | (First, Middle                      | , Maide  | n Sumar   | me)            |  |
| Maryland                   | ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Heelih and Mental Hygiene. If Item 27 Is marked other then "naturel", or iteme 23e or 28e-f show or other treumatic event, the Medical Examiner must be notified at   | ToB              |  | Don                                   | D                 | ster                   | •  |            |                           |                     |           | Ruth         |                                     | Hil]     | ,         |                |  |
| <u>-</u>                   | J Mari   | Ĕ                | 40- Info-ments No  |                                       |                   | scer                   | 1  | ** ***     |                           |                     |           |              |                                     |          |           |                |  |
| B                          | 2 sl   |                  | 19a. Informant's Na  | ime/Helationship (                    | rype, Print)      |                        | 190  | . Mailin   | g Address                 | (Street a           | ınd Num   | ber or Hura  | al Route Numb                       | er, City | or Town   | , State, Zip   | Code)  |
|                            | and<br>selth<br>n 27   |                  | Nancy Lo   | well/ Fr                              | i end             |                        | 46   | 5 St       | . An                      | drew                | s Rd      | ., Sev       | erna P                              | ark,     | MD        | 21146          |  |
| <u> </u>                   | S H E  |                  | 20a. Method of Disp  | osition                               |                   |                        | 20b. Place of  | Dispo      | sition (Nar               | me of               | -1        |              | Date                                | 20c.     | Location  | - City or To   | wn, State                                      |
| 2                          | 200 mm mm mm mm mm mm mm mm mm mm mm mm m  |                  |  | Cremation 3 ☐<br>5 ☐ Other (Specif    |                   | State                  | Kalas  |            | ,                         | •                   | 9)        | 12-22        | 0.5                                 | 17.3     | ~~.       | L              | MT.  |
| Baltimore,                 | permit. Pages 1 and 2<br>Department of Heelth a<br>Importent: If item 27 le<br>eny Injury or other tre<br>ance.  |                  | 21. Signature of Fur   |                                       |                   |                        | Natas  |            |                           | -                   |           |              |                                     |          |           | ter, 1         |  |
| a                          | Departr<br>Departr<br>Imports<br>eny Inj   |                  | 21. Signature of Fur   | neral Service Licer                   | 1500              |                        |  |            |                           |                     |           |              |                                     |          |           |                | al Home  |
| ш                          | ₹0 5 € d   |                  | / /win   | 10 Wes                                |                   |                        |  | 29         | 973 S                     | olom                | ons       | Islan        | d Rd.                               | Edg∈     | wate      | er, MD         | 21037  |
|                            |  |                  | 23a. rart1. Enter th   | e disease, or com                     | plications that   | caused th              | ne death. Do r   | not ente   | er the mod                | de of dyin          | g, such a | s cardiac c  | or respiratory a                    | arrest,  |           |                | Approximate<br>Interval Between                |
|                            |  |                  | snock, or near   | t failure. List only                  |                   |                        |  |            |                           |                     |           | 0            |                                     |          |           |                | Interval Between<br>Onset and Death            |
|                            | Physician  |                  | disease or condition   | n                                     | a Cont            | act                    | Shorty   | n          | on e                      | 7                   | s ho      | ed           |                                     |          |           | - 1            |  |
|                            | /Medical   |                  | resulting in death)  |                                       | Due to            | (or as a               | conseque ce  | of):       |                           |                     |           |              |                                     |          |           |                |  |
|                            | Examiner   |                  |  |                                       |                   |                        |  |            |                           |                     |           |              |                                     |          |           |                |  |
|                            |  | 9                | Sequentially list con  | nditions,                             | b. Due to         | (or as a               | consequence  | offe       |                           |                     |           |              |                                     |          |           | -              |  |
| 1                          | per ist  | 든                | Sequentially list con<br>cause. Enter Under<br>Cause (Disease or i | rlying                                |                   |                        |  | •          |                           |                     |           |              |                                     |          |           |                |  |
| V                          | ecut<br>end<br>-trar   | Examiner         | that initiated events resulting in death) L                        |                                       | c                 |                        |  | -          |                           |                     |           |              |                                     |          |           |                |  |
| oʻ                         | en e   |                  | rosalling in coaliny E   |                                       | Due to            | (or as a               | consequence  | of):       |                           |                     |           |              |                                     |          |           |                |  |
| 92                         | ysic<br>b bu   | ca               |  |                                       | d                 |                        |  |            |                           |                     |           |              |                                     |          |           |                |  |
| 68760,                     | The law requires that the death certificate be executed to has been signed by the ettending physicien end bage 2 should be deteched for use as the burial-transit  | hysician/Medical |  |                                       |                   |                        |  |            |                           |                     |           |              |                                     |          |           |                |  |
| Вох                        | ding   | 3                | IF FEMALE:   |                                       | 23c. If yes, ou   | itcome of              | oreonancy  |            |                           |                     |           |              |                                     |          |           |                |  |
| Bo                         | ath<br>or u  | lan              | 23b. Was decedent<br>in the past 12 r                              |                                       | 1 Live            | birth 2                | Fetal death  |            | Ectopic pr                |                     |           |              |                                     |          |           | ate of deliver | ry<br>Day Year                                 |
| 0.                         | e de<br>he e   | Sic              | 1 ☐ Yes 2 ☐  | No                                    | 4∐Preg<br>9☐ Unkr |                        | me of death  | 5 🗆        | Other (sp                 | pecify)             |           |              |                                     |          | 7410      | or itti        | Day rear                                       |
| 9.                         | by t<br>tech   | ķ                | 9 Unknown  |                                       | 0000              |                        |  |            |                           |                     |           |              |                                     |          |           |                |  |
|                            | the de   | Y                | Part II. Other signifi   | cant conditions                       | ontributing to    | death but              | not resulting in   | the ur     | nderlying c               | ause give           | n in Parl | 1.           | 23e. Did                            | tobacco  | use can   | tribute to the | e cause of death?                              |
| S                          | S S S  | d by             |  |                                       |                   |                        |  |            |                           |                     |           |              | 10                                  | Yes :    | 2 Z/No    | 3 ☐ Proba      | ably 4 Dunknown                                |
| ō                          | tw requires that<br>s been signed !<br>s should be det   | Completed        |  |                                       |                   |                        |  |            |                           |                     |           |              |                                     |          |           |                |  |
| O                          | has b  | ğ                |  |                                       |                   |                        |  |            |                           |                     |           |              | 24a. Was                            |          | 24b.      | Were autop     | osy findings available<br>npletion of cause of |
| œ                          | The te h   | O                |  |                                       |                   |                        |  |            |                           |                     |           |              |                                     | ormed?   |           | death?         | npietion of cause of                           |
| a                          | in:  | O                | 25 Mas agas reform   | and to market                         |                   |                        |  |            |                           |                     |           | _            | 1 Xes                               | 2□ N     | 0         | 1 PYes         | 2 No   |
| ₹                          | icie<br>ectri  | 8                | 25. Was case referrence examiner?                                  |                                       | Hospital:         |                        |  |            | -                         | T Out               |           |              | Check only                          |          |           |                |  |
| <u></u>                    | Physicien:<br>this certific<br>rat director.   | ၉                | Yy Yes 2□ I  |                                       | 1                 | Inpatient              | 2 ER/Ou  | tpatien    | t 3 DC                    | Othe Othe           | 4   N     |              | me 5□Res                            |          |           |                | Scene  |
| 5                          | ter t  | Ë                | 27. Manner of Death<br>1 ☐Natural                                  |                                       | 28a. Date         | of Injury              |  | rime of    | 2                         | 28c. Injury<br>Work | at ?      | 1            | 28d. Describe                       |          | ,         | de             |  |
| <u>ō</u>                   | Attending or deeth.  ector: After by the fune  | atic             | 2 Accident   | 5 Pending investigation               | LOG A - AV        |                        |  | 1,28,      |                           |                     | res 2[    | Olde         | Subje                               | It si    | hot.      | seif           |  |
| 15                         | dee<br>cto   | Ę.               | 3 Suicide  | 6 Could not b                         | 8 28e Ptac        | -                      | y - At home, fa  |            |                           | v office            |           | 20.00        | V                                   |          |           |                | Route Number,                                  |
| Division of Vital Records, | l or Attend<br>efter deeth<br>Director: A<br>d in by the fi  | Certification:   | 4 Homicide   | determined                            | build             | ling, etc.             | (Specity)  | , •        | 301, 140101)              | y, 0.110 <b>0</b>   |           |              | City or To                          | wn, Sta  | te)       |                | Le   |
|                            | ret<br>ret   |                  |  |                                       | 1                 |                        | Lone   |            |                           |                     |           |              |                                     |          | An        | napol          | is MO  |
|                            | To the Hospital or Attending Physicien: The I within 24 hours elien death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page  | Medicai          | 29a. Certifier<br>(Check only                                      | 1☐ Certifying Ph<br>2XXMadical Exar   | ysician: To the   | e best of              | my knowledge   | , death    | occurred                  | at the tim          | e, date a | ind place, a | and due to the                      | cause(   | s) and m  | anner as sta   | ated.  |
|                            | 24 Pro H   | ed               | one)   | ZAMINGION ZX                          | and mar           | ner state              | ed.  | CP OF ITTE | restigation               | i, in my of         | onion, de | ath occurr   | ed at the time,                     | date ar  | na piace, | and due to     | the cause(s)                                   |
|                            | o the state of the | ž                | 29b. Signature and   | title of certifier                    |                   |                        |  |            | 290                       | c. License          | number    |              |                                     | 29d. D   | ate signe | d (Month, E    | Day, Year)                                     |
|                            | ->-0   |                  | 1  | 1. 1                                  | y                 | 0                      |  |            |                           | 0~-                 |           |              |                                     |          |           |                |  |
|                            | ,  |                  | Jan  | me /                                  | Jose              | V                      | MO   |            |                           | OCME                | j         |              |                                     | Dece     | embei     | <u>r, 17</u> , | , 2005   |
|                            | á  |                  | 30. Name and addre   | ess of person ho                      | completed cau     |                        | th (Item 23a)  | (Туре, І   | Print)                    |                     |           |              |                                     |          |           |                |  |
|                            | 0  |                  | Tasha Z  | Greenb                                | en M              | Δ.                     |  |            | 11                        | ll Pe               | nn S      | treet        | Balt                                | imo      | re, l     | Marvla         | and 21201                                      |
|                            | Sta  | te               | 31. Date liled (Monti  |                                       |                   | gistrar                | s Signature  | - /        |                           |                     |           |              |                                     |          |           |                |  |
|                            | Registr  |                  |  | DEC3 0;                               | 2005              | Post in                | · K  | 1          | rock                      | P                   |           |              |                                     |          |           | 4              | •  |
|                            | F 13   |                  |  |                                       | -300              | Contract of the second | A STATE OF THE STA | 800        | 100                       | /                   |           |              |                                     |          |           |                |  |

|                |   | •              | For<br>State<br>Registrar  |  | State  | of Mary  | land / Dep<br><i>Ce</i>             |                                    | of Health   |                |                                     | ene<br>g.2005                 | 5 4                       | 2277                                    |
|----------------|---|----------------|--|--|--|--|-------------------------------------|------------------------------------|---|----------------|-------------------------------------|-------------------------------|---------------------------|---|
|                | right .   |                | Decedent's Name  | (First, Midd                           | le, Last)                                      |  |                                     |                                    |   |                | 2. Date of Death<br>Month           |                               |                           | . Time of Death                         |
|                | Physici /Medic  |                | PRAMOD   | DESAI                                  |  |  |                                     |                                    |   | E              | DEC                                 | 10 200                        | )5 7                      | :35 P <sup>M</sup>                      |
|                | Examin  |                | 4a. Facility Name (If SHADY G  |  |  |  |                                     |                                    | own, or Locatio                                   | n of Death     |                                     | 4c. County of                 |                           |   |
|                | Funeral   |                | 5. Sociat Security No  |  | 6. Sex<br>1 <b>X</b> M 2 ☐ F                   |  | yrs. last birthday                  | ) If Under 1                       |   | er 24 Hrs.     | 8. Date of Birth                    |                               |                           | (State or Foreign                       |
| J.             | Director  |                | 039-32-2   |  | 1 <b>2</b> M 2 □ F                             | 6  | 7 Yrs.                              | Months                             | Days  | · · · · · · •  | CT 2T,                              | 1938                          | ADAM.                     |   |
|                | ryland<br>how   |                | Usual Residence of<br>10a. State                                     | 10b. County                            | OMERY  |  | c. City, Town or I                  |                                    |   |                |                                     |                               |                           | Inside City Limits                      |
|                | Be-f e  | ecto           |  |  | OPIEKI   | G  | ATTHERS                             |                                    |   |                |                                     | 0111                          |                           | 1 Dyes 2 No                             |
|                | with the or 2   | <u> </u>       | 10e. Street and Nun 12213 QU   |  | WAT.T.EV                                       | DB   |                                     | 10f. Zip (                         |   |                |                                     | g. Citizen of Wh              | at Country?               |   |
| 21215-0036     | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow or other traumatic event, the Medical Examinar must be notified at | by Funera      | 11. Marital Status 1 Never Marrie 3 Widowed                          | ed 2 <mark>M</mark> Mar<br>4 ∏Divorced | 12. Was D Armed 1 □ Ye If Yes, Year o          | ecedent Ever<br>Forces?<br>s 2 No                        |                                     | . Was Decede<br>If Yes, speci      | ent of Hispanic (<br>fy Cuban, Mexic<br>XNo Speci |                | ify Yes or No-<br>ican, etc.)       | 14. Race<br>Black,<br>Specify | American I<br>White, etc. |   |
| 215-           | thin 72<br>8.<br>9n "nat<br>Medic   | Completed      | (Speci   | ify only highe                         | nt's Education<br>est grade complete<br>Cotleg | ed)<br>e (1-4or 5+)                                      | (Giv                                | DO NOT use                         | c done durina m                                   | ost of working | 9                                   | 6b. Kind of Busi              |                           |   |
| 7              | ygiene<br>ygiene<br>yer the   | Con            |  |  |  | 5+   | ENGI                                | NEER                               | 10.11   |                |                                     | CONSTRU                       |                           | N                                       |
| land           | uld be filed<br>fental Hygie<br>rked other<br>lic event, II   | To Be          | 17. Father's Name (  |  |  |  |                                     |                                    |   | ITA I          | (First, Middle, M<br>DESAI          | aiden Sumame,                 |                           |   |
| Maryland       | and 2 should<br>balth and Men<br>n 27 is marke<br>ier traumatic   |                | 19a. Informant's Na<br>MAHESH  |  |  |  |                                     |                                    |   |                | Route Number,  DR GA                |                               |                           | MD 20878                                |
| Baltimore,     | permit. Pages 1 and 2<br>Department of Health<br>Important: If Item 27 i<br>eny injury or other tru   |                | 20a. Method of Disp<br>1 Burial X<br>4 Donation  21. Signature of Fu | Cremation 5 Cother (                   |  | om State   | ATIONAL                             | ematory or oth  CREM  22. Name and | her place)<br>IATORY<br>I Address of Fac          | cilityNAT]     | 3/05 FZ                             | UNERAI                        | URCH                      | , VA                                    |
|                | Physician   |                | Immediate Cause (  | rt failure. Lis<br>Final               | r complications the                            | at caused the  |                                     | nter the mode                      | of dying, such                                    | as cardiac or  | respiratory arre                    | st,                           | Int                       | proximate<br>erval Between<br>iset DAYS |
|                | /Medical<br>Examiner  |                | resulting in death)  |  |  | to (or as a co   | nsequence of):                      |                                    |   |                |                                     |                               |                           |   |
|                | po iis  | Iner           | Sequentially list con<br>any, leading to me<br>cause. Enter Unde     | nditions,<br>madiata<br>rlying         | b. Oue   | to (or as a co   | пвецианев об:                       |                                    |   |                |                                     |                               |                           |   |
| 8760,          | cate be executed<br>physicien and<br>the burial-transit   | dical Examiner | Cause (Disease or<br>that initiated events<br>resulting in death) L  | Last                                   | c. Due   | to (or as a co   | nsequence of):                      |                                    |   |                |                                     |                               |                           |   |
| .O. Box 68     | requires that the death certifica<br>been signed by the attending ph<br>hould be detached for use as t  | Physician/Med  | IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown    | months?                                | 1 □ Liv<br>4 □ Pr                              | outcome of p<br>re birth 2 c<br>egnant at time<br>aknown | Fetal death 3                       | □Ectopic pre                       |   |                |                                     | 23d. Date<br>Monti            | ,                         | y Year                                  |
| <u>α</u>       | quires that<br>n signed b   | ٥              | Part II. Other signif  |  | -  |  | ot resulting in the                 | underlying ca                      | use given in Pa                                   | n I.           | 23e. Did tob                        | acco use contrib              |                           | ause of death?  4 □Unknown              |
| Vital Records, | The law<br>ate has t<br>page 2 s  | Completed      |  |  |  |  |                                     |                                    |   |                | 24a. Was an autopsy perform         | 00                            |                           | findings available<br>etion of cause of |
| Vita           | Physicien: Th<br>this certificate<br>ral director, pag  | Be             | 25. Was case reference examiner?                                     |  |  | _  |                                     |                                    | Other   |                | (Check only one                     |                               |                           |   |
|                | × 5   | n: To          | 1 Yes 2  | h                                      | 28a. Da  | Inpatient<br>ate of Injury<br>fonth, Day Ye              | 2 ER/Outpati<br>28b. Time<br>lnjury | of 28                              | Bc. Injury at Work?                               |                | e 5 Resider                         |                               |                           |   |
| Division of    | o the Hospital or Attending Phinin 24 hours after death. o the Funeral Director: After the completely filled in by the funeral  | Certification: | Natural Accident Suicide Implicate                                   | 6 Could                                | igation<br>I not be 28e. Pt                    |  | At home, farm,                      | М                                  | 1 ☐ Yes 2   |                | 8f. Location (Str.<br>City or Town, | eet and Number<br>State)      | or Rural Ro               | oute Number,                            |
| Ω              | Hospital of 24 hours af Funeral Distely filled in   | edical Cer     | 29a. Certifier<br>(Check only  | Certifyi                               | ng Physician: To<br>I Examiner: On th          | the best of m  | y knowledge, de                     | ath occurred a                     | at the time, date                                 | and place, ar  | nd due to the ca                    | use(s) and man                | ner as state              | d.                                      |
|                | To the h<br>within 24   | Medi           | one) 29b. Signature and  |  | and m  | nanner stated  |                                     |                                    | License numbe                                     |                |                                     | d. Date signed                |                           |   |
|                | T N O   |                | Signature and  | Ah                                     | MD   |  |                                     |                                    | 3262  |                |                                     | 2/10/0                        | -                         | ,                                       |
| 0              | (23/  |                | 30. Name and addr  |  |  |  |                                     | e, Print)                          |   |                |                                     | w.                            |                           |   |
| 1000           | Sta   | ate            | 31. Date filed (Mon  | th, Day, Year                          | )  | 2. Registrar's   | Signature                           |                                    | TLLE, M   | <u>w 2085</u>  | U                                   |                               |                           |   |
| 100            | Regist  | rar            | 520  | 146                                    | 2000   | de.  | 15 for                              | 1                                  |   |                |                                     |                               |                           |   |

| 1 Charlest Name (Proc. Match. Last)  William C. Dennis  William C. Dennis  1 Special Company of Com |      |                                  |         | 1 - For State Registrar                                    | • •                                  | yland / [                   | Department of F<br>Certificate of                 | Health and M                                   | lental Hyg        | •                     | 42278   |
|--|------|----------------------------------|---------|--|--------------------------------------|-----------------------------|---|--|-------------------|-----------------------|---|
| Security Number   Proposed State and number   Proposed State   Proposed St |      |                                  |         |  | t)                                   |                             |   |  | 2. Date of Dear   | th                    | 3. Time of Death                                  |
| Examiner    Second processes   Contract of Cashin   Contract   Con | 97   |                                  |         | William  | C. Dennis                            | 3                           |   |  | Decemb            | er 7,200              | 5 1:50рм  |
| Discourse of the control of the cont | 100  |                                  |         |  |                                      | #111                        |   |  |                   |                       | ath   |
| Total Silve   100 Country      |      |                                  |         | 225-54-4124  | ØM 2□E                               | -                           | Months Days                                       |  | (Month, Dav.      | 9. Bi<br>20,1944 V    | rthplace (State or Foreign<br>Country)<br>irginia |
| 1. Fallin's Name (Frigs. Micidis, Macken Sumane)   |      | land<br>ow                       |         |  | 1                                    | Oc. City, Town              | or Location                                       |  |                   |                       | 10d. Inside City Limits                           |
| 1. Fallin's Name (Frigs. Micidis, Macken Sumane)   |      | Many<br>-feh                     | to      | Md. P.G.   |                                      | Oxon                        | Hill  |  |                   |                       | 1√ Yes 2 No                                       |
| 1. Fallin's Name (Frigs. Micidis, Macken Sumane)   |      | r 28e                            | irec    | 10e. Street and Number                                     |                                      |                             | 10f. Zip Code                                     |  | 1                 | 0g. Citizen of What C | Country?  |
| 1. Fallin's Name (Frigs. Micidis, Macken Sumane)   |      | th wit                           | aiD     | 7911 Indian Hea  | d Hwv #1                             | 11                          | 20745   |  | IJ                | LS.A.                 |   |
| 1. Fallin's Name (Frigs. Micidis, Macken Sumane)   |      | dea                              | ner     |  | 12. Was Decedent Ev                  |                             |   |  |                   | 14. Race - Am         |   |
| 1. Fallin's Name (Frigs. Micidis, Macken Sumane)   | 9000 | ours after<br>traft, or tte      | d by Fu |  | 1 ☐ Yes 2 ☑ No<br>If Yes, Give       |                             |   |  | Alcan, etc.)      |                       |   |
| 1. Fallin's Name (Frigs. Micidis, Macken Sumane)   | 5-   | 72 h                             | ete     | 15. Decedent's Ed<br>(Specify only highest gra-            | ucation<br>de <i>completed)</i>      | 16a.                        | Decedent's Usual Occup<br>(Give kind of work done | ation<br>during most of worki                  | ing               | 16b. Kind of Business | s/Industry  |
| T. Fallins Stame (First, Middle, Macken Sumanne)   Mattile Meadows   | 121  | vithin<br>ne.<br>han             | m       | Elementary/Secondary (0-12)                                | College (1-4or 5+)                   |                             |   | d)   |                   | Gaint Fo              | od  |
| Physician // (Approximate special properties)  Physician // (Approximate | 2    | Hygie<br>Hygie<br>ther t         |         |  |                                      | wa                          | renouse   | 19 Mother's Name                               | /First Middle 1   | Maidas Sumama         |   |
| Physician // (Approximate special properties)  Physician // (Approximate | and  | od ol                            | Be      |  | C                                    |                             |   |  |                   | · ·                   |   |
| Physician // (Approximate special properties)  Physician // (Approximate | Z    | d Me<br>d Me<br>mark<br>matic    | ۲       |  |                                      | 10b                         | Mailing Address (Street                           |  |                   |                       | 7:- 0- 4-1  |
| Physician // (Approximate special properties)  Physician // (Approximate | Ma   | d2s<br>than<br>7 is 1            |         |  |                                      |                             | -   |  |                   |                       |   |
| Physician // (Approximate special properties)  Physician // (Approximate |      | 1 an<br>Heali<br>em 2            |         |  | ayne-sist                            |                             |   |  |                   |                       |   |
| Physician // (Approximate special properties)  Physician // (Approximate | ПŌ   | ages<br>nt of<br>t: ff  t        |         | 1X Burial 2 ☐ Cremation 3 ☐                                |                                      | cemeter                     | y, crematory or other place                       | cal  |                   |                       |   |
| Physician // (Approximate special properties)  Physician // (Approximate | Ē    | it. Purtue                       |         |  |                                      |                             |   |  |                   |                       |   |
| 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory areast.    Continued the cause (in the cause)   Continued the c | Ba   | Depi<br>Impo                     |         |  |                                      |                             |   | •  | Eads              | St.N.E                |   |
| Physician (Medical Examiner  The part of t |      | 3 %)                             |         | 23a. Part1. Enter the disease, or comp                     | olications that caused th            | e death. Do n               |   |  |                   |                       | Approximate                                       |
| The statistics of the statisti |      | St1-1-1                          |         |  | and the same                         | 100                         | 10  | Di mac.  | ,                 | ,                     | Interval Between                                  |
| State   Sequentially list conditions, and, leading to minediate   Course of pregnancy and properties of the post 12 months?   Due to (or as a consequence of):   |      |                                  |         | disease or condition                                       | a                                    | Stag                        | Le vienice  | Hexer Je                                       | •                 |                       |   |
| The search of th |      |                                  |         |  | Due to tor as a c                    | Sonsequence of              | Molling   |  |                   |                       | 1 1100n   |
| The search of th | **   |                                  | ē       | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a c                 | consequence                 | of):  |  |                   |                       | - year  |
| FEMALE:   23c. If yes, outcome of pregnancy   1   1   1   1   1   1   1   1   1  |      | uted<br>d<br>ansit               | 듄       | cause. Enter Underlying Cause (Disease or injury           | the                                  | Derfer                      | 1 Sins  |  |                   |                       | 992ans  |
| 1  | Ć,   | execuna and and ital-tra         | Exa     |  | Due to (or as a)                     | on sequence o               | of):  |  |                   |                       |   |
| 1  | 192  | ysicia<br>ysicia                 | cai     | (  | d                                    |                             |   |  |                   |                       |   |
| 1  | 99   | ntifica<br>ng ph<br>as th        | ledi    | IS SEMALE.   |                                      |                             |   |  |                   |                       |   |
| 1  | ŏ    | th ce<br>tendii<br>r use         | an/N    | 23b. Was decedent pregnant                                 |                                      |                             | 3 DEctopic pregnancy                              | ,  |                   |                       |   |
| 1  |      | dea<br>he att                    | sici    | 1 ☐ Yes 2 ☐ No   | 4 ☐ Pregnant at tim                  |                             |   |  |                   | Month                 | Day Year  |
| 1  | P.0  | at the                           | Phy     |  |                                      |                             |   |  |                   |                       |   |
| 1  |      | igner<br>be d                    | by      | Part II. Other significant conditions co                   | - At 10                              | Δ.                          | the underlying cause giv                          | en in Part I.                                  |                   | . /                   |   |
| 1  | ord  | neen s                           | ted     | - AY   | less alles                           | arua                        | <u>.</u>  |  | 1 □ Ye            | s 2ЩИо 3∐Р            | robably 4 Unknown                                 |
| 1  | ec   | las b                            | npie    |  |                                      |                             |   |  | autops            | y prior to            | utopsy findings available completion of cause of  |
| 1  | H    | The cate h                       | Sol     |  |                                      |                             |   |  |                   | ned? death?           |   |
| 1  | /ita | ertific<br>actor,                | a)      | examiner?  |                                      |                             |   |  | (Check only one   | 9)                    |   |
| 1  | =    | hysi<br>this c                   | -       | 1 165 2 1140   | 1 Unpatient                          |                             | patient 30 DOA                                    | 4   Nursing non                                | ne 5 Reside       | nce 6 Other (Spe      | ecify)  |
| 29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and delete the cause of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only of Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature   | ū    | ing F                            | on:     | + /  | 28a. Date of Injury<br>(Month, Day Y | (e <i>ar</i> ) 28b. T       |   |  | 28d. Describe ho  | w injury occurred     |   |
| 29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and delete the cause of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only of Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature   | Sic  | tend<br>death<br>tor: /<br>the f | cat     |  |                                      |                             |   |  |                   |                       |   |
| 29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and delete the cause of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature  29a. Certifier (Check only of Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filled (Month, Day, Year)  32. Registrar's Signature   | Σ    | i the                            | artif   | data — is a d  | 286. Place of Injury                 | - At nome, far<br>'Specify) | m, street, factory, office                        | 2  |                   |                       | ural Route Number,                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SANTIAGO D. MORAD, JR., M.D., 6357 Dxon Will Rd. Dxon Hill  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | _    | Hospitel                         |         | (Check only 2 Madicel Exam                                 | iner: On the basis of ex             | camination and              | death occurred at the tin                         | ne, date and place, a<br>pinion, death occurre | and due to the ca | use(s) and manner as  | s stated.<br>e to the cause(s)                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SANTIAGO D. MORAD, JR., M.D., 6357 Dxon Will Rd. Dxon Hill  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature   |      | ithin (                          | Mec     |  | and manner stated                    | J.                          | 29c Licens  | e number                                       | 20                | nd Date signed (Most  | th Day Yearl                                      |
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| DEC 1 4 2005   |      | Sta                              | te      |  | 32. Registrar's                      | Signature                   | h ma  | * ) /  | V -CV F1 /1       | i i i i col           | CAST 14/11/10                                     |

| Physician Richard Arlan Etzler  Seaton St. Solid Backety Market 2005 Second St. 217 Age days and and cumber)  Director St. Solid Backety Market 2005 Second St. 217 Age days and and cumber)  Director St. Solid Backety Market 2005 Second St. 217 Age days and and cumber)  Director St. Solid Backety Market 2005 Second St. 217 Age days and and cumber)  Director St. Solid Backety Market 2005 Second St. 217 Age days and and cumber)  Director St. Solid Backety Market 2005 Second St. 217 Age days and and cumber)  Director St. Solid Backety Market 2005 Second St. 217 Age days and and and and and and and and and and   |               |   | •     | 1 - State<br>Registrar                                     | State of Maryland /   | •              | ertment of<br>tificate o |                   |                      | , ,  | ne<br>2.005            | 7                         | 2279   |
|--|---------------|---|-------|--|---|----------------|--------------------------|-------------------|----------------------|--|------------------------|---------------------------|--|
| ## Richard Arien Exzler   December 12 2005   12:08P   ## Arien   Exzler   Arien   Exzler   December 12 2005   12:08P   ## Arien   Exzler   Arien   Exzler   Arien   Exzler   Arien   Exzler   ## Arien   Exzler   Arien   Exzler   Arien   Arien   Exzler   Arien   Ar |               |   |       |  | )   |                |                          |                   | 2                    | . Date of Death                              | to the                 |                           | 3. Time of Death                                   |
| ## Familiary of Dear Section (Section Section) against a control of the Courty of Dear Production of the Dear Production of the Dear |               |   |       | Richard Ar   | len Etzler  |                |                          |                   | D                    | ecember                                      | 12 200                 | Year<br>05                | 12:08P M   |
| Security Numbers   1, Survey   | 1             |   |       | 4a. Facility Name (If not institution, give                | street and number)  |                | 4b. City, Town           | , or Location o   | of Death             |  | 4c. County             | of Death                  | <u> </u>   |
| 214-28-1132   15M = F 73 vs.   Months   Carry   Stock   Mn.   Feb. 4, 1, 322   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   and   Marry   Marry   and   Marry   Marry   and   Marry   Marry   and   Marry   Marry   and   Marry   |               |   | u     | 202 S. Second St   | •   |                | Wood                     | dsboro            |                      |  | Fre                    | eder                      | ick  |
| Text      |               |   |       |  |   | * 1            |                          |                   | 24 Hrs. 8.<br>Min. F | Date of Birth<br>(Month, Pay, Y<br>eb. 14,19 | 932                    | 9. Birthp<br>Cour<br>Mary | place (State or Foreign<br>http:<br>  land         |
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| Noy 1. Etzter - Drother S828 Saint Annes Dr., Fayetville, PA 17222  20a Method of Disposition 1  | <u>\</u>      | ould<br>Mer<br>narke                          | 유     |  |   |                |                          |                   |                      |  |                        |                           |  |
| 20a. Method of Disposation    The Burst   28 Constant   10 meth (Speech)   20b (or as a consequence of)   20b (or as a conse | Mai           | d 2 st<br>th and<br>7 fan<br>traun            |       |  |   |                | _                        |                   |                      |  |                        |                           | ,  |
| Barrial 2 & Commation   12/14/05   Sykesville, MD  |               | 1 and<br>Healt<br>em 2                        |       |  |   |                |                          | Annes             |                      |  |                        |                           |  |
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| Physician Medical Examiner    Page    |               | 40 = 4 Q                                      |       |  |   |                |                          |                   |                      |  |                        |                           |  |
| Part   Company   |               |   |       |  | ne cause on each line;                                      |                | 1 0                      | 1                 |                      | - 6  | ,                      |                           | Approximate<br>Interval Between<br>Onset and Death |
| Sequentially list conditions, cause. Enter Underlying Cause (Disease of Injury or swilling in death) Last   Due to (or as a consequence of):   | 1             | •   |       | disease or condition                                       | a Theros  |                | rtic                     | cardio            | OVASC                | uler   | diseas                 | e                         |  |
| The state of the s |               |   |       |  | Dué to (or as a consequence                                 | ce of):        |                          |                   |                      |  |                        |                           |  |
| The state of the s |               |   | ē     | Sequentially list conditions, if any, leading to immediate |   |                |                          |                   |                      |  |                        |                           |  |
| State   Stat   |               | uted  | min   | cause. Enter Underlying Cause (Disease or injury           |   |                |                          |                   |                      |  |                        |                           |  |
| State   Stat   | Ć.            | execting and items                            | Еха   |  | Due to (or as a consequence                                 | ce of):        |                          |                   |                      |  |                        |                           |  |
| FFEMALE:   23b. Was deededn pregnant in the past 12 months?   1   Yes   2   No   20   Unknown   23c. If yes, outcome of pregnancy   1   1   Yes   2   No   20   Unknown   23c. If yes, outcome of pregnancy   1   1   Yes   2   No   20   Unknown   23c. If yes, outcome of pregnancy   1   1   Yes   2   No   20   Unknown   23c. If yes, outcome of pregnancy   1   1   Yes   2   No   20   Unknown   23c. If yes, outcome of pregnancy   1   1   Yes   2   No   20   Unknown   23c. If yes, outcome of pregnancy   1   1   Yes   2   No   23c. Did tobacco use contribute to the cause of death?   1   Yes   2   No   3   Probably 4   Unknown   24c. War a suppost performed   23c. If yes, outcome of pregnancy   1   Yes   2   No   3   Probably 4   Unknown   24c. Was an autopsy performed   23c. If yes outcome of pregnancy   1   Yes   2   No   3   Probably 4   Unknown   24c. Was an autopsy performed   23c. Was case referred to medical   25c. W   | 19/           | ysicia<br>ysicia                              | cal   | (  | d   |                |                          |                   |                      |  |                        |                           |  |
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| 25. Was case referred to medical 26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Death (Check only one)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury (Month, Day Year)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  28. Place of Injury (Month, Day Year)  29. Clerifier (Check only one)  29. Signature and title of certifier  29. License number  290. Date signed (Month, Day Year)  290. Date signed (Month, Day Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day Year)  32. Registration of the basis of cause of death (Item 23a) (Type, Print)  33 | သို့          | law re  | plet  |  |   |                |                          |                   |                      |  | 24b. W                 | ere auto                  | psy findings available                             |
| Value of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28d. Describe how injury occurred  28d. Describ | Ä             | The<br>ate his<br>page                        | E O   |  |   |                |                          |                   |                      | performe                                     | d?_   de               | eath?                     |  |
| Impatient   2   ER/Outpatient   3   DOA   3   Nursing Home   3   State   4   Nursing Home   4   Nursing Ho   | İta           | striffical<br>ctor.                           | a     |  |   |                |                          | 26. Place         | of Death (C          |  | ,,,,,                  |                           |  |
| State   Stat   | ) _           | g .is   |       |  | 1 Inpatient 2 EH  | Outpatien      | t 3 DOA                  | Other: 4 Nu       | rsing Home           | Residence                                    | e 6 Othe               | r (Specify                | <i>'</i> )   |
| 29b. Signature and duries of person who completed cause of death (Item 23a) (Type, Print)  State  2   Accident 3   Suicide 4   Homicide 4   Homicide 4   Homicide 5   State 5   Home and address of person who completed cause of death (Item 23a) (Type, Print)  2   Accident 3   Suicide 4   Homicide 5   Could not be determined 5   State 5   Home and address of person who completed cause of death (Item 23a) (Type, Print)  2   Accident 3   Suicide 4   Homicide 5   Could not be determined 6   Could not be det |               |   |       |  | 28a. Date of Injury 28t<br>(Month, Day Year)                |                | 28c. In                  | ijury at<br>Vork? | 280                  | d. Describe how                              | injury occurre         | d                         |  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature   | sio           | tent<br>leati<br>tor:<br>the                  | cat   | E  |   |                |                          |                   | -                    |  |                        |                           |  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and due to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filed (Month, Day, Year)  32. Registrar's Signature   | Σ             | or At<br>after of<br>Direction by             | il.   |  | 28e. Place of Injury - At home,<br>building, etc. (Specify) | farm, stre     | eet, factory, offic      | Э                 | 281                  | City or Town, S                              | et and Numbe<br>State) | r or Rura                 | l Route Number,                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gene Ashe, M.D.  10200 Coppermine Road P.O. BOX 6 Woodsboro, Maryland 21798  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |               | pital<br>ours a<br>eral<br>filled             |       | 29a Certifier 1 Certifying Phy                             | sician: To the host of my knowled                           | dan doath      | a consumed at the        | time date and     | d place, and         | due to the sour                              |                        |                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gene Ashe, M.D.  10200 Coppermine Road P.O. BOX 6 Woodsboro, Maryland 21798  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |               | 24 h<br>e Fun<br>etely                        | dica  | Check only 2 Medical Exami                                 | ner: On the basis of examination                            | and/or inv     | estigation, in m         | y opinion, deat   | th occurred          | at the time, date                            | and place, a           | nd due to                 | the cause(s)                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gene Ashe, M.D.  10200 Coppermine Road P.O. BOX 6 Woodsboro, Maryland 21798  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |               | Mithin<br>Fo th<br>compl                      | Me    | 29b. Signature and title of certifier                      |   |                |                          |                   |                      | 29d.   | Date signed            | (Month, i                 | Day, Year)   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene Ashe, M.D.  10200 Coppermine Road P.O. BOX 6 Woodsboro, Maryland 21798  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature  |               |   |       |  | ahe un  |                | D00                      | 031058            |                      |  | 12-13-2                | 2005                      |  |
| 10200 Coppermine Road P.O. BOX 6 Woodsboro, Maryland 21798  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |               | M30   |       | 30. Name and address of person who                         | ompleted cause of death (Item 23                            | a) (Type,      | Print) G                 | ene Ash           | ne, M.               |  |                        |                           |  |
|  |               | 1.  |       |  |   |                |                          |                   |                      |  |                        |                           |  |
|  |               |   | -     |  |   |                | 1                        |                   |                      |  |                        |                           |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month FRANK ROOSEVELT EPPS DECEMBER 09, 2005 4:00P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5809 PLATA STREET CLINTON PRINCE GEORGES If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** XXM 2□F Director Yrs. 578 48 6528 FEB. VIRGÍNIA 22, 1938 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 27 Is marked othar than "natural", or Itams 23s or 28a-1 show traumatic avant, the Nedical Examinar must be notified at 10d. Inside City Limits XX Yes 2 □ No PRINCE GEORGES MARYLAND CLINTON Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 5809 PLATA STREET 20735 UNITED STATES death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

Is marked othar than "natural", or Itar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: BLACK XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER 12TH AUTOMOBILE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ FRANK EPPS BARBARA WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is IT any injury or othar traum <u>once.</u> JULIANNE R. EPPS / DAUGHTER 5809 PLATA ST. CLINTON, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) MT. OLIVET CEMETERY 12/14/2005 WASHINGTON, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) PARKINSONS DISEASE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and a burial-transit Due to (or as a consequence of): Box 68760 certificate be Physician/Medical nding phys use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown s been signed by the should be detached Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by DIABETES 1 ☐ Yes ŽŽNo 3 Probably 4 Unknown Completed HYPERTENSION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2/2/No certificate 1 ☐ Yes 1 Yes 2 No the Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? To Hospital: Other: 4 Nursing Home XX Residence 6 Other (Specify) 1 ☐ Yes XXNo 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After XXNatural 5 Pending after death. investigation 1 Yes 2 No 2 ☐ Accident Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a XX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) Medi To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D02975 12/13/05 30. Name and address of person who dom cause of death (Item 23a) (Type, Print) 11345 PEMBROKE SQUARE ST. 104 WALDORF, MD 20603 . Registrar's Signature 31. Date filed (Month, Day, Year) DEC 1 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 4:36 A M DECEMBER 2005 **EDMUNDS** 11SERENA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HYATTSVILLE PRINCE GECRGE'S CRESCENT CITIES NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🔯 F Months Days Hours 83 APRIL 24 1922 WASHINGTON, DC Director 216-12-5610 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "naturaf", or itams 23a or 28a-f show the Medical Expedient rount by notified at 1 X Yes 2 ☐ No Director LANHAM PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. 20716 9017 CRANDALL ROAD Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT FOOD SERVICE 11th . Pages 1 and 2 should be filed viment of Health and Mental Hygie tant: if itam 27 is marked othar i jury or othar traumatic event. It 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOSEPHINE HAWKINS MCKINLEY PATTERSON 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 3803 92nd AVENUE SPRINGDALE, MARYLAND JEAN TURNER/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. RESURRECTION CEMETERY 12/15/05 CLINTON, MARYLAND <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HYPERTENSIVE CARDIO VASCULAR DISEASE Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) DIABETES MELLITUS Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician a P.O. Box 68760. Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy atten for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) per the 9 🗆 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, by ATHEROSCLEROTIC VASCULSR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown ted peen Comple 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an Rheumatoid Arthritis autopsy performed? has certificate Hyperlipidemia 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? 1 ∰Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 2 this funeral 27. Manner of Death 1 Anatural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending Injury death. investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide after within 24 hours a 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D48213 December 13, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEELAM ASHAI M.D. 4410 74th AVENUE LANDOVER, MARYLAND 20784 31. Date filed (Month, Day, Year) Registrar's Signature State 1 6 2005 Registrar

|   | 1 - State of Maryland / Department<br>Registrar Certificate  |  | ental Hygier<br>Reg.                              | 211115                                   | 42282  |
|---|--|--|---|--|--|
| - No. 187   | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death<br>Month                         | Day Year                                 | 3. Time of Death                                 |
| Physician<br>/Medical   | Edward William Evans, Jr.  |  | December  | 11, 2005                                 | 7:50 A <sup>M</sup>                              |
| Examiner  | 44. I dointy i dailed (it included)  | own, or Location of Death                                      |   | 4c. County of Death                      |  |
|   | Joseph Richey Hospice  5. Social Security Number  6. Sex 7. Age (In yrs. last birthday) If Under 1   |  | 8. Date of Birth                                  | 9. Birth                                 | place (State or Foreign                          |
| Funeral Director  | 096-42-2714 1 M 2 F 55 Yrs. Months   | Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Ye<br>March 5, 1 | 950 Conn                                 | ecticut  |
| ъ   | Usual Residence of Decedent  |  |   |  |  |
| show  | 10a. State 10b. County 10c. City, Town or Localion   |  |   |  | 10d. Inside City Limits 1 ☐ Yes 2 XNo            |
| or 28a-f s  | Maryland Anne Arundel Glen Burnie  | Code   | 100   | Citizen of What Cou                      |  |
| With With   | 298 K Mountain Ridge Court 2106  |  |   | ited Stat                                | Ť  |
| or Items 23s  | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decede  | int of Hispanic Origin? (Spe<br>y Cuban, Mexican, Puerto F     |   | 14. Race - Ameri<br>Black, White         | can Indian,                                      |
|   | Amed Forces? If Yes, specific forces and the specific forces are specific forces. If Yes specific forces are specific forces and the specific forces are specific forces.  |  | nicati, etc.)                                     | Specify: Whi                             |  |
| 72 hours a real Evaluation of the following | 3 Widowed 4 N Divorced Year or Dates:  | Occupation   | 104   | . Kind of Business/îi                    |  |
| od within 72 ho<br>ygjene.<br>her then "natur.<br>f., the Medical.  | 15. Decedent's Education 16a. Decedent's Usual (Specify only highest grade completed) (Give kind of work life. DO NOT use  | Occupation<br>done during most of working<br>retired)          | ng 160  | . Kind of business/if                    | idustry  |
| d withing glene.  | Elementary/Secondary (0-12) College (1-4or 5+) 4 Sale  | esman  |   | Restauran                                | t Supply   |
| ylang 2  ould be filed a  Mental Hygis  arked other satic event, II   | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name  | (First, Middle, Maid                              | den Sumame)                              |  |
| Viand build be fill Mental H Mental H arked oth artic even  | Edward William Evans, Sr.  | Loribel S  |   |  |  |
| Mar<br>d 2 sho<br>th and<br>7 le m<br>traum   |  | Street and Number or Rura                                      |   |  |  |
| C, n<br>1 and<br>Health<br>Am 27<br>ther t  | 20a Method of Disposition 20b. Place of Disposition (Name  | al Ridge Lan   |   | I, Mary Lan Location - City or T         |  |
| ages<br>intofin<br>refit  | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  1 Baltimore Crema  |  |   | ltimore,                                 |  |
| Darmit. Pages 1 Department of H important: if its any injury or ot  |  | Address of Facility  | hn M Tav  | lar Funer                                | al Home, Inc.                                    |
| Page 1  | Michael Ollon 147 Duk  | e of Glouces   |   |  |  |
| ESSE!   | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.   | of dying, such as cardiac of                                   | r respiratory arrest,                             |  | Approximate<br>Interval Between                  |
| Physician   | Immediate Cause (Final disease or condition  | d Cancer   |   |  | Onset and Death 2 ULK                            |
| /Medical<br>Examiner  | resulling in death)  Due to (or as a consequence of):  |  |   |  | J  |
| 140 136   | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):   |  |   |  |  |
| executed executed and transit Examiner  | cause. Enter Underlying Cause (Disease or Injury that initiated events  c.   |  |   |  |  |
| O,<br>exec<br>en an<br>mal-tri  | resulting in death) Last Due to (or as a consequence of):  |  |   |  | ****   |
| cate be executed physicien and the burial-transit clical Examir   | d  |  |   |  |  |
|   | IF FEMALE: 23c. If yes, outcome of pregnancy   |  |   | 22d Date of della                        |  |
| that the death certification of the attending detached for use as Physician/Me  | 23b. Was decedent pregnant in the past 12 months?  1 Dive birth 2 Fetal death 5 Other (specific pregnant at time of death 5 Other (specific pregnant at ti |  |   | 23d. Date of deliving Month              | Day Year   |
| the day the ached   | 1 Yes 2 No 9 Unknown   |  |   |  |  |
| ords, r<br>requires that<br>een signed b<br>hould be deta   |  | use given in Part I.   | 23e. Did tobacc                                   | co use contribute to                     | the cause of death?                              |
| wrequires that wrequires that should be dett  |  |  | 1 🗌 Yes   | 2 No 3 Pro                               | bably 4 Sucknown                                 |
|   |  |  | 24a. Was an autopsy                               | prior to co                              | opsy findings available<br>ompletion of cause of |
| - " # a   C   |  |  | performed   | ? death?                                 | 2 No   |
| Or VITal Physician: T this certificat ral director, p:  | examiner?  | 26. Place of Death   |   | 200000                                   |  |
| P y a site is before  | To tes aprilo To inpatient 2 Ervoutpatient 3 DOA   | 4   Aursing Hon  | ne 5 Residence<br>28d. Describe how in            |  | Hoguer   |
| nding Fath.   | 1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation M  | Work?<br>1 ☐ Yes 2 ☐ No  |   |  |  |
| DIVISION C Let or Attending P is after death. at Director: After t ed in by the funera Certification:   | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, Iarm, street, lactory, building, etc. (Specify)   | office 2   | 28f. Location (Street<br>City or Town, S          | t and Number or Rui<br>tate)             | al Route Number,                                 |
|   |  |  |   |  |  |
| DIVISIO DIVISIO Attendi n 24 hours after death. he Funeral Director: A pletely filled in by the fi  | 29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at (Check only one) 1. Certifying Physician: To the basis of examination and/or investigation, i and manner stated.   | it the time, date and place, a<br>in my opinion, death occurre | and due to the cause<br>ed at the time, date      | e(s) and manner as<br>and place, and due | stated.<br>to the cause(s)                       |
| To the Hos<br>within 24 h<br>To the Fun<br>completely   | 29b. Signature and little of certifier 29c.  | License number   | 29d.  | Date signed (Month                       | Day, Year)                                       |
|   | D. William Benedick mis -  | 0609583  | i   | 2/11/05                                  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |   |  |  |
|   |  | REST. B  | altimore:   | द तल्ली ड                                | 127  |
| State<br>Registrar  | 050  | •  |   |  |  |

|                            | -12.00  |                | 1 - For Amend Item 2<br>State<br>Registrar  | State of M.<br>23a per D               | arylan          | d/Depa<br>353,037     | rtmer<br>tifica | t of H<br>6dhb<br>ie of L               | ealth a<br>Death | nd Me        | ntal Hyg                      | jiene<br>1eg. No. | 005                     | No. of the last of | +228                           | 33        |
|----------------------------|---|----------------|---|--|-----------------|-----------------------|-----------------|---|------------------|--------------|-------------------------------|-------------------|-------------------------|--|--------------------------------|-----------|
| 4.5                        | Physicia  | 30             | 1. Decedent's Name (First, Middle, Last   | )                                      |                 |                       |                 |   |                  | 2            | Date of Dea<br>Month          | ith<br>Day        | Ye                      | ar   | 3. Time of                     |           |
|                            | /Medic  |                | ETHEL BLANCHE   | EBERSOLE                               |                 |                       |                 |   |                  |              | Decemb                        |                   |                         | 05   | 231                            | 4 M       |
|                            | Examin  | er             | 4a. Facility Name (If not institution, give   |  |                 |                       | 4b. City        |   | Location of      |              |                               | 4G.               | County of I             |  | TC/TP∕NT                       |           |
|                            |   | <i>3</i> h     | WASHINGTON COUNTY 5. Social Security Number 6. Se   |  |                 | last birthday)        | If Unde         | nAG<br>r 1 Year                         | ERSTO            | 4 Hrs. 8     | Date of Birth                 | 1                 |                         |  | IGTON<br>ace (State of<br>try) | r Foreian |
|                            | Funeral<br>Director   | į              |   | ]M 2 <b>∑</b> [F                       | 81              | Yrs.                  | Months          | Days                                    | Hours            | Min.         | Month, Day                    | , Year)<br>19:    |                         |  | try)<br>SYLVAN                 |           |
|                            | p ,   |                | Usual Residence of Decedent  10a. State 10b. County   |  |                 | y, Town or Lo         | antina          |   |                  |              |                               |                   |                         |  |                                |           |
|                            | ehov<br>ehov  | 5              |   | OTTON:                                 | 100.01          | y, TOWITOT LO         | Cation          | 1217                                    | EDVOV            | TT T T       |                               |                   |                         | '  | 0d. Inside Cit<br>1 🖺 Yes      | -         |
|                            | h the Maryland<br>or 28a-f ehow<br>notified at  | Directo        | MARYLAND WASHIN  10e. Street and Number   | GTON                                   | L               |                       | 10f. Z          | D Code                                  | EDYSV.           | الماليا الم  |                               | 10a. Citi;        | zen of Wha              | t Coun   | try?                           |           |
|                            | 3a or   |                | 3708 TREGO MOUNTA   | TN ROAD                                |                 |                       |                 |   | 21756            |              |                               |                   | U.S.                    |  |                                |           |
|                            | death   | Funeral        | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?      |                 | .S. 13.               | Was Dece        | dent of Hi                              |                  | in? (Specif  | y Yes or No-                  | 1                 | 14. Race<br>Black, \    | Americ   |                                |           |
| õ                          | ours after death with   |                | 1 Never Married 2 Marned  | 1 ☐ Yes 2 🔯                            |                 |                       | 1 ☐ Yes         |   | Specify:         | 1 40110 1111 | Jan, Sto.,                    |                   | Specify:                |  |                                |           |
| 215-UU36                   | hours after death with the Maryland<br>ture!; or Iteme 23a or 28a-f ehow<br>al Examiner must be notified at   | d by           | 3 ☑ Widowed 4 ☐ Divorced  | Year or Dates:                         |                 |                       |                 |   |                  |              |                               |                   |                         |  | HITE                           |           |
| ς<br>L                     | within 72 ho<br>liene.<br>r then "natur<br>he Medical   | Completed      | 15. Decedent's Edu<br>(Specify only highest grad  | le completed)                          |                 |                       | kind of w       | iai Occupa<br>ork done d<br>ise retired | during most      | of working   |                               | 16b. Kii          | nd of Busin             | ess/inc  | lustry                         |           |
| 717                        | r than  | mo             | Elementary/Secondary (0-12)   | College (1-4or                         | 5+)             |                       | Pi              | RESSE                                   | R                |              |                               | CLO               | THING                   | MAN  | UFACT                          | URE       |
| פ                          | be filed<br>tat Hygi<br>d other<br>event,   | Bec            | 17. Father's Name (First, Middle, Last)   |  |                 |                       |                 |   | 18. Mother       | r's Name (F  | First, Middle,                | Maiden            | Sumame)                 |  |                                |           |
| <u>a</u>                   |   | To E           | CLEMETH BURNSWORT   | H                                      |                 |                       |                 |   |                  |              | MILLE                         |                   |                         |  |                                |           |
| Maryland                   | 2 shc<br>and<br>and<br>raum   |                | 19a. Informant's Name/Relationship (7)  |  |                 |                       |                 |   |                  |              | Route Numbe                   |                   |                         |  |                                | 756       |
|                            | s 1 and 2 should<br>of Health and Mer<br>Item 27 is marks<br>other traumatic  |                | DAVID L. EBERSOLE  20a. Method of Disposition   | JR./SON                                | 20b. F          | 3708 Place of Dispo   |                 |   | NTAIN            | ROAD         | , KEED                        |                   | و تابلط<br>cation - Cit |  |                                |           |
| Ö                          | 0 0 = =   |                | 1 Burial 2 □ Cremation 3 □ F  |  |                 | cemetery, crer        | natory or       | other plac                              | 1                |              |                               |                   |                         |  |                                |           |
| saltimore,                 | 그 문원를 .   |                | 4 □Donation 5 □ Other (Specify, 21. Signature of Fundral Service Licens                                     |  | SA              | MPLES 1               | -               |   | ss of Facility   |              | 2005<br>606 01                |                   |                         |  | MARYL                          | AND       |
| E<br>E                     | Depe<br>Impo<br>eny l   |                | De Cours Marie  | Paul Paul                              | M. D            |                       |                 |   | AL HO            | ME '         | oonsbo                        |                   |                         |  |                                | 13        |
| G-W                        | Aut.  |                | 23a. Part 1. Enter the disease of comp<br>shock, or heart failure. List only of                             | lications that caused                  | d the deat      | th. Do not ent        | er the mo       | de of dyin                              | g, such as o     |              |                               |                   |                         |  | Approximate<br>Interval Bet    | 9         |
|                            | Physician   |                | Immediate Cause (Final disease or condition   | 4467                                   |                 |                       | <b>Term</b> i   | nal.                                    | Aspira           | ation        |                               |                   |                         |  | Onset and I                    |           |
|                            | /Medical<br>Examiner  |                | resulting in death)   | Due to (or as                          | a consec        | quence of):           |                 |   |                  |              |                               |                   |                         | 1  | ich                            |           |
| В                          | Cxamine   | _              | Sequentially list conditions,   | b. — Due to for as                     |                 | was a of)             |                 |   |                  |              |                               |                   |                         | -  |                                |           |
|                            | ted<br>nsit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as                          | a consec        | querice or):          |                 |   |                  |              |                               |                   |                         |  |                                |           |
|                            | execunand and al-tra  | Exar           | that initiated events<br>resulting in death) Last   | c<br>Due to (or as                     | a consec        | quence of):           |                 |   |                  |              |                               |                   |                         |  |                                |           |
| 8760                       | icate be executed<br>physicien and<br>s the burial-transit  | dical          |   | d                                      |                 |                       |                 |   |                  |              |                               |                   |                         |  |                                |           |
| Ó                          |   | Medi           | IF FEMALE:  |  |                 |                       |                 |   |                  |              |                               |                   |                         |  |                                |           |
| Вох                        | leath certific<br>ettending pl  | an/l           | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome<br>1 ☐ Live birth |                 |                       | Ectopic         | oregnancy                               | ,                |              |                               | 2                 | 23d. Date o             |  | *                              | 'ear      |
| o.                         | the el  | Physician/Me   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant a<br>9□Unknown              | t time of c     | death 5               | Other (s        | specify)                                |                  |              |                               |                   | WOTE                    |  | Day                            | oa:       |
| പ്                         | The law requires that the death certific<br>sie has been signed by the ettending p<br>page 2 should be detached for use as  |                | Part II. Other significant conditions co  | intributing to death b                 | out not res     | sulting in the u      | nderlying       | cause giv                               | en in Part I.    |              | 23e. Did to                   | bacco u           | se contribu             | te to th   | e cause of d                   | eath?     |
| ds,                        | uires<br>sign<br>ld be  | d by           | and tree  | onamie                                 | Pera            | in se                 | . dr            | ne                                      | 0                | CVA          | 1 🗆 Y                         | 'es 2[            | ]No 3(                  | ] Prob   | ably 4.21                      | Inknown   |
| Ö                          | w require<br>been si<br>should I  | lete           |   | 1                                      |                 | 1                     |                 |   |                  |              | 24a. Was                      | an                | 24b. Wei                | e auto   | osy findings                   | available |
| Re                         | rsician: The law<br>s certificate has t<br>lirector, page 2 s   | Completed      |   |  |                 |                       |                 |   | ····-            |              | autop                         | med?              | prio                    | r to cor<br>th?  | npletion of ca<br>2 □ No       | ause of   |
| ta                         | tifica<br>tor, p  | 0              | 25. Was case referred to medical  |  |                 |                       |                 |   | 26. Place        | of Death (   | t □ Yes<br>Check only o       | 2 Z No            | 1 1 1                   | 1 85   | 2 🗆 NO                         |           |
| <u></u>                    | Attending Physician: or death. ector: After this certificaby the funeral director, is   | To B           | examiner?<br>1 Yes 2 No   | Hospital:<br>1 ☐ Inpati                | ent 2           | ER/Outpatier          | nt 3 🗆 🗅        | Oth Oth                                 | er: 4 🗆 Nur      | rsing Home   | 5 ☐ Resid                     | lence (           | 3 □Other (              | Specify  | ')                             |           |
| 0                          | ding Ph<br>h.<br>After th<br>funeral  |                | 27. Manner of Death  1. Natural 5 □ Pending   | 28a. Date of Inju<br>(Month, Da        | ury<br>ay Year) | 28b. Time o<br>Injury |                 | 28c. Injun<br>Work                      |                  |              | d. Describe h                 | ow injur          | y occurred              |  |                                |           |
| Sio                        | tend<br>Jeath<br>tor: A   | cat            | 2 Accident investigation 3 Suicide 6 Could not be   | 00- 81                                 |                 | 1                     | М               |   | Yes 2 N          |              | 4.1                           | 244               | 4.85                    |  |                                |           |
| Division of Vital Records, | l or Attended efter death Director:   | Certification: | 4 Homicide determined   | 28e. Place of In<br>building, e        | tc. (Speci      | fy) tarm, sti         | reet, facto     | ry, office                              |                  | 28           | f. Location (S<br>City or Tox | m, State          | d Number (              | or Hura  | i Houle Num                    | ber,      |
| _                          | To the Hospital or Attending Physician: The within 24 hours eliter death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page |                | 29a. Certifier 1 Cartifying Phy   | /sician: To the best                   | of my kno       | owledge, deat         | h occurre       | d at the tin                            | ne, date and     | d place, an  | d due to the                  | cause(s)          | and mann                | er as st   | ated.                          |           |
|                            | To the Hospital within 24 hours. To the Funerel completely filled   | edical         | (Check only 2 Madical Exam  | iner: On the basis of<br>and manner st | of examina      | ation and/or in       | vestigatio      | n, in my o                              | pinion, deat     | th occurred  | at the time,                  | date and          | place, and              | due to   | the cause(s                    | )         |
|                            | To the H<br>within 24<br>To the FI<br>complete  | Ž              | 29b. Signature and title of certifier   |  |                 |                       | 2               | 9c. Licens                              | e number         |              |                               | 29d. Dat          | e signed (A             | Aonth.   | Day, Year)                     |           |
|                            |   |                | Alfred  |  |                 |                       |                 | かるみ                                     | 518              |              |                               | 12/               | 2/00                    |  |                                |           |
| γi,                        | Pilo  |                | 30. Name and address of person who o  |  | 0 -             | 0 3                   | Print)          | £)                                      | pol.             | V < .1:      | lle                           | MA                | ry la                   | no   |                                |           |
|                            | 되면<br>Sta   | ato            | 31. Date filed (Month, Day, Year)   | 31 L                                   | rar's Sign      |                       | , , , ,         |   |                  | 7301         |                               | ,                 | 1 ,50                   |  |                                |           |
| 1                          | Regist  |                | DEC 192   | 005                                    | and a           | 19. 1                 | Cost alls       | · ·                                     |                  |              |                               |                   |                         |  |                                |           |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day **Physician** 27, Sister Denise Eby Dec. 2005 11:35 A.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner St. Vincent Care Center Emmitsburg Frederick If Under 1 Year 5. Social Sacurity Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral**  Birthplaca (Stata or Foraign Country) Days Months Hours 1 □ M 2 🖫 F Yrs Director 88 219-05-0817 Dec. 8, 1917 Maryland Usual Rasidence of Decedant 10a. Stata 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1X Yas 2 □ No Director Frederick Emmitsburg 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 335 S. Funeral Seton Avenue 21727 U.S.A. 14. Race - Amarican Indian, 11 Marital Status 12. Was Decadant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours after. Department of Health and Mantal Hygione. Important: If Item 27 is marked other than "nature." Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 1 Mayar Marriad 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 2 Spacify: 3 ☐ Widowad 4 ☐ Divorced White Completed 16e. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Religious Community College 5+ Teacher Daughters of Charity 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Surnama) Be ္ရ Charles Arthur Eby Ethel Ciscle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) 333 S. Seton Avenue, Emmitsburg, MD Sister Camilla Harant 21727 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata ST. JOSEPH P.H 12/29/2005 EMMITSBURG, MD. 21727 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Nama and Addrass of Facility SKILES FUNERAL HOME of Funeral Service Licensaa 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 Entar tha disease, or complications that causad the daath. Do not anter tha mode of dying, such as cardiac or raspiratory arrest, or heart failura. List only one causa on eech line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disaasa or condition resulting in death) /Medical Examiner Dua to (or es a consequança of). Examiner The lew requires that the death certificate be axecuted ohysician and the bunal-trensit Sequantially list conditions, if any, leading to immadiate causa. Enter Undarlying Causa (Disease or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Box 68760. Mensia Physician/Medical oua to (or as a consequence of): ettending p signed by the e P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 27 No 3 Probably 4 □ Unknown Division of Vital Records. à 24b. Wara autopsy findings availabla prior to completion of causa of death? Completed 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No or Attending Physician: Be 25. Wes casa referred to madical examiner? 26. Place of Daath (Chack only one) Hospital: 1 ☐ Inpatiant Othar: 4 X Nursing Homa 5 Assidence 6 Other (Spacify) ဥ 1 ☐ Yes 2 ☒ No 2 ER/Outpatient 3 DOA this funeral 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Panding death. invastigation 1 Yes 2 No Director: A 2 Accidant 6 Could not be 3 ☐ Suicida Place of Injury - At home, farm, straat, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) end manner stated. edicai (Check only 29b. Signature and titla of certifian 29c. Licanse number 29d. Date signad (Month, Day, Yaar) DECEMBER 27, 2005 30. Name and addrass of person who completed cause of daath (Itam 23a) (Type, Print) ALAN CARROLL. 310 S. SETON AVE EMMITSBURG, MD. 21727 M.D31. Data filed (Month, Day, Year)
DEC 3 0 32. Segistrer's Signature State 2005 SELAR. Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2005 DECEMBER 25, PAUL EDWARD ECKENRODE 8:10 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BRADDOCK HEIGHTS VINDOBONO NURSING HOME FREDERICK 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN.12,1910 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F Hours Min. 95 Director Yrs. THURMONT, MD. 212-28-0042 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 17 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examination must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 No MD FREDERICK BRODDOCK HEIGHTS 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 6012 JEFFERSON BLVD. 21714 Funerai U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If flem 27 Is marked other than "natural", or Iten any injury or other traumatic event, I're Medical Exertirations. Black, White, etc. 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ 3X Widowed 4 ☐ Divorced Specify: Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 FACTORY WORKER FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CHARLES EDWARD ECKENRODE ပ MARY KELLY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1579 ANDOVER LA. FREDERICK, PATRICK E. ECKENRODE/SON MD. 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. ANTHONY'S ^ 4 □ Donation 5 □ Other (Specify) 12/29/05 EMMITSBURG, MD. 21727 21. Signatu e 1 Fun de l'Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727-0427 241. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dise or condition resumed in death) Osperation

Due to or as a consequence of): Physician reumonia veeks /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit certificate be executed ding physician and Due to (or as a consequence of): Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Po in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 No To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🕅 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Kathleen W Stein 1732073 DECEMBER 27, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stern MD 610 Ninth Lathleen W. 31. Date filed (Month, Day, Year) 32. gistrar's Signature State DEC 3 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 3:20 AM England Gardner 12 24 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Sacred Hospit Allegan Heart If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, Apr 25, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1₩ 2□F MD 213-22-2666 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or Itama 23s or 28e-1 show amy injury or other traumatic avant. Its Medical Exprine from the notified an once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 19 Potomac Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give X Year or Dates: Specify Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 **B&O** Railroad fireman/engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul W. England Mildred Atwell England ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19 Potomac Street MD 21502 wife Cumberland Mildred England 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 12/28/2005 Cumberland MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Nama and</sup> Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tallue **Physician** /Medical Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the attending physicien end hed tor use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant al time of death 5 Other (specify) detached ģ this certificate has been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 3 ☐ Probably 4 ☐Unknown Be Completed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one Hospital: Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 Natural 5 Pending death. Il Diractor: A investigation 1 Yes 2 No Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide determined within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 24,2005 100 56355 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 902 Seton Drive, Cumberland Mark Nelson 21502 land

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 3

2005

| Jose<br>05-08 | Richard | Esco | to                       |
|---------------|---------|------|--------------------------|
| NJM           | 5510    | 1-   | For<br>State<br>Registra |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a, perME, 351, 1/19/05 TI

|                            |  |                | 1 - State<br>Registrar   | State of Ma   |                       | partment of the ertificate of                    |   |                                    | giene 00                                   | 5 42287                               |  |  |  |  |
|----------------------------|--|----------------|--|---|-----------------------|--|---|------------------------------------|--|---------------------------------------|--|--|--|--|
|                            | Physici  | 20             | Decedent's Name (First, Middle, La.  | st)   |                       |  |   | 2. Date of Dea<br>Month            | ith<br>Day Yea                             | 3. Time of Death                      |  |  |  |  |
|                            | Physici<br>/Medio  |                | Jose Richard Esc   | coto  |                       |  |   | Decembe:                           |  | 1.4                                   |  |  |  |  |
|                            | Examir   |                | 4a. Facility Name (If not institution, giv   | e street and number)  |                       | 4b. City, Town, o                                | or Location of Death                        | 1                                  | 4c. County of D                            | eath                                  |  |  |  |  |
|                            |  |                | Washington Adver   | ntist Hospi   | tal                   | Takoma   | Park  |                                    | Montgome                                   | ery                                   |  |  |  |  |
|                            | Funeral  |                | 5. Social Security Number 6. S   | ex 7. Age<br>OXIM 2□ F  | (In yrs. last birthda | /) If Under 1 Year<br>Months Days                |   | 8. Date of Birth                   | (Year)                                     | Birthplace (State or Foreign Country) |  |  |  |  |
|                            | Director   |                | 579-15-3776  | AW ZUI  | 23 Yrs.               |  |   | 08-24-1                            | 982 Wa                                     | shington, D.C                         |  |  |  |  |
|                            | and  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town or    | Location   |   |                                    |  | 10d. Inside City Limits               |  |  |  |  |
|                            | Manyl<br>f sho   | ច              | Maryland P.G.  |   |                       |  |   |                                    |  | 1√2 Yes 2 □ No                        |  |  |  |  |
|                            | 28a-   | Directo        | 10e. Street and Number   |   | Hyatts                | 10f. Zip Code                                    |   |                                    | 10g. Citizen of Whal                       | 21                                    |  |  |  |  |
|                            | 72 hours after deeth with the Maryland<br>natural; or Iteme 23a or 28a-f show<br>dical Examinar must be collified at   | ā              | 7994 Riggs Road  |   |                       | 20783  | 1   | -                                  | U. S. A.                                   | Country                               |  |  |  |  |
|                            | ne 23  | Funeral        | 11. Marital Status   | 12. Was Decedent E  | ver in U.S. 13        |  |   | pecify Yes or No-                  |  | merican Indian,                       |  |  |  |  |
| <b>'</b> O                 | fler of the result of the resu | Ē              | 1 X Never Married 2  Married   | Armed Forces?<br>1 ☐ Yes 2 X No   |                       | . Was Decedent of I<br>If Yes, specify Cub       |   | Rican, etc.)                       |  | hite, etc.                            |  |  |  |  |
| ဗ္ဗ                        | urs a  | b              | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:  |                       | ¹Xi Yes 2□ №<br>EI Salvad                        | Specify:<br>Oran                            |                                    | Specify: V                                 | Vhite                                 |  |  |  |  |
| 21215-0036                 | 72 ho  | Completed      | 15. Decedent's E   | ducation  | 16a. Dec              | edent's Usual Document                           | pation                                      |                                    | 16b. Kind of Busine                        | ss/Industry                           |  |  |  |  |
| 2                          | hin Mark   | ple            | (Specify only highest gra<br>Elementary/Secondary (0-12)   | College (1-4or 5+   | ) (Gr                 | e kind of work done DO NOT use retire            | during most of wonder)                      | ong                                | Daintin                                    | g Company                             |  |  |  |  |
| 2                          | og er th   | 50             | 9th  |   | Pa                    | inter  |   |                                    | rainting                                   | g company                             |  |  |  |  |
| p                          | d oth  | Be             | 17. Father's Name (First, Middle, Last,  |   |                       |  |   |                                    | Maiden Surname)                            |                                       |  |  |  |  |
| <u> </u>                   | Meni Meni  | မှ             | Jose Luis Solito   | Guerra  |                       |  |   | rma Esco                           |  |                                       |  |  |  |  |
| Maryland                   | 2 sh<br>and<br>le m  |                | 19a. Informant's Name/Relationship (   | Type, Print)  | 19b. Ma               | ling Address (Street<br>4 Riggs Ro               | and Number or Rui                           | ral Route Numbe.                   | r, City or Town, State Md. 20783           | a, Zip Code)                          |  |  |  |  |
|                            | and<br>lealth<br>m 27  |                | Maria Elena Esco   | to (Siste   | r)                    | 1  |   |                                    |  |                                       |  |  |  |  |
| 0                          | ges<br>If of h   |                | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐  | Removal from State  | cemetery, cr          | ematory or other pla                             | ce)   |                                    | 20c. Location - City                       |                                       |  |  |  |  |
| ‡                          | t. Pa<br>tmen<br>tant:   |                | 4 □Donation 5 □ Other (Specif  | -   |                       |  | -   |                                    | Washingt                                   |                                       |  |  |  |  |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or iteme 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be collided at Once.   |                | 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility W. H. Bacon Funeral Home, Inc.                    |   |                       |  |   |                                    |  |                                       |  |  |  |  |
|                            |  |                | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only   | SIGCON, C   | 00011                 |  |   |                                    |  | Approximate                           |  |  |  |  |
|                            | Pnysician<br>/Medical<br>Examiner  | er             | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to introducte | b   | consequence of):      | e gunshot w                                      | The Hare                                    | torsa                              |  | Onset and Death                       |  |  |  |  |
|                            | uted<br>1<br>Insit   | m<br>F         | if any, leading to sinthediate cause. Enter Underlying Cause (Disease or injury  |   |                       |  |   |                                    |  |                                       |  |  |  |  |
| Ć,                         | ficate be executed<br>physicien and<br>s the burial-transit  | Examin         | that initiated events<br>resulting in death) Last  | Due to (or as a   | consequence of):      |  |   |                                    |  |                                       |  |  |  |  |
| 68760,                     | se be  | edical         |  | d   |                       |  |   |                                    |  |                                       |  |  |  |  |
| _                          | ± Ο α  | ed             |  |   |                       |  |   | -                                  |  |                                       |  |  |  |  |
| P.O. Box                   | law requires that the death certifes been signed by the attending es been signed by the attending to 2 should be detached for use a  | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  | 23c. If yes, outcome o<br>1 □ Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown | Fetal death 3         | ☐Ectopic pregnanc                                | у   |                                    | 23d. Date of o<br>Month                    | delivery<br>Day Year                  |  |  |  |  |
|                            | w requires that been signed is should be det   | by P           | Part II. Other significant conditions of   | ontributing to death bul  | nol resulting in the  | underlying cause giv                             | en in Part I.                               | 23e. Did to                        | bacco use conIribute                       | to the cause of death?                |  |  |  |  |
| ğ                          | quire<br>an sig  |                |  |   |                       |  |   | 1 🗆 Y                              | es 2.X No 3□                               | Probably 4 Unknown                    |  |  |  |  |
| S                          | aw re<br>ss ber<br>2 sho   | Completed      |  |   |                       |  |   | 24a. Was a                         |  | autopsy findings available            |  |  |  |  |
| ĕ                          | e - %  | mo             |  |   |                       |  |   | autops                             | med? death                                 |                                       |  |  |  |  |
| ta                         | iiclan: Th<br>certificate<br>rector, pag   | BeC            | 25. Was case referred to medical   |   |                       |  | 26. Place of Deat                           |                                    | 1  | es 2 No                               |  |  |  |  |
| >                          | ysici<br>is ce<br>direc  | ToB            | examiner?<br>t√xYes 2 □ No   | Hospital: 1 Inpatien  | t 2/0/ER/Outpati      | ent 3 DOA Oth                                    |   | - N - N - N                        | ence 6 □Other (S)                          | Decify)                               |  |  |  |  |
| Division of Vital Records, | Attending Physician:<br>r death.<br>ector: After this certifics<br>by the funeral director, i  |                | 27. Manner of Death  | 28a Date of Injury<br>(Month, Day   | 28b. Time             |  |   |                                    | ow injury occurred                         | 1 /                                   |  |  |  |  |
| Ö                          | ath.<br>or: Af   | atic           | 1 □ Natural 5 □ Pending 2 □ Accident investigation   |   | 19 = 05               |  | Yes 2 No                                    | subject                            | was  | shot                                  |  |  |  |  |
| Vis                        | r Atte<br>er de<br>recto<br>by th  | tific          | 3 Suicide 6 Could not b<br>4 Memicide determined   | 28e. Place of Injur<br>building, etc.   | y - Al home, farm, s  | treet, factory, office                           |   | 28f. Location (Si                  | treet and Number or                        | Rural Route Number                    |  |  |  |  |
| ۵                          | tal or<br>rs efte<br>ef Dir  | Certification; |  | M a   | purkin 9              | lot  |   | Hyatter                            | n. State) 2306                             | University 1814                       |  |  |  |  |
|                            | To the Hospital or Attending Physician:<br>within 24 hours efter death.<br>To the Funerel Director: After this certific<br>completely filled in by the funeral director,   | edlcai         | 29a. Certifier   1 ☐ Certifying Ph<br>(Check only<br>onle)   X Medical Exam  | ysician: To the best of<br>niner: On the basis of a<br>and manner state         | examination and/or    | nth occurred at the til<br>nvestigation, in my o | me, date and place,<br>opinion, death occur | and due to the cred at the time, d | ause(s) and manner<br>ate and place, and d | as stated.<br>ue to the cause(s)      |  |  |  |  |
|                            | To the within 2 To the complet   | ž              | 29b. Signature and title of certifier  |   |                       | 29c. Licens                                      | se number                                   | 2                                  | 9d. Date signed (Mo                        | nth, Day, Year)                       |  |  |  |  |
|                            |  |                | > high   | i, mi   |                       | C  | CME   | De                                 | ecember, 1                                 | 0, 2005                               |  |  |  |  |
|                            | 12)  |                | 30. Name and address of person who   |   | ath (Item 23a) (Type  |  | _   |                                    | _  |                                       |  |  |  |  |
|                            | 1  |                |  | I, mit  | 1-0:                  | III Pe   | nn Street                                   | Baltir                             | nore, Mary                                 | land 21201                            |  |  |  |  |
|                            | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  DEC 1 4 2005  |   | 's Signature          | 4.   |   |                                    |  |                                       |  |  |  |  |
|                            | MH 17 Roy 1/2  |                | DEO 1 4 2003   | July 1  | No 1400               |  |   |                                    |  |                                       |  |  |  |  |

|            |  |  | For State Registrar   | State of M   | aryland                |                         | artmen                      |                             |              |            |  | jiene          | 005                         | 42288  |  |
|------------|--|--|---|--|------------------------|-------------------------|-----------------------------|-----------------------------|--------------|------------|--|----------------|-----------------------------|--|--|
|            | Dhyaisi  |  | 1. Decedent's Name (First, Middle   | , Last)  |                        |                         |                             |                             |              |            | 2. Date of Dea<br>Month                    | th<br>Day      | Year                        | 3. Time of Death                                   |  |
|            | Physici<br>/Medi   |  | LILLIAN CAMI  |  |                        |                         |                             |                             |              |            | Decembe                                    | 10             |                             | 6:10 a <sup>M</sup>                                |  |
| 7          | Examir   | ner  | 4a. Facility Name (If not institution   | •  | •                      |                         | 4b. City,                   | Town, or                    | Location of  | of Death   |  | 4c. Co         | unty of Death               | 1  |  |
|            |  |  | Calvert County 5. Social Security Number  |  | enter, age (In yrs. la |                         | Pri<br>If Under             |                             | Fred         |            |  |                | lvert                       |  |  |
|            | Funeral<br>Director  |  | 579-20-2905   | 1 □ M 2 X F  | 92                     | Yrs.                    | Months                      |                             | Hours        | Min.       | 8. Date of Birth<br>(Month, Day<br>July 14 | Year)          | 9. Birth<br>Con             | pplace (State or Foreign untry) hington, DC        |  |
|            |  |  | Usual Residence of Decedent   |  |                        |                         |                             |                             |              |            | July 14                                    | 171            | J Was                       | nington, be  |  |
|            | rylan<br>how   |  | 10a. State 10b. County  |  | 10c. City,             | Town or Lo              | ocation                     |                             |              |            |  |                |                             | 10d. Inside City Limits                            |  |
|            | the Marylan<br>28a-f show  | Director   | Maryland Calver   | t  | Hun                    | tingt                   | own                         |                             |              |            |  |                |                             | 1 X Yes 2 ☐ No                                     |  |
|            | with th  | Dire   | 10e. Street and Number  | 7  |                        |                         | 10f. Zip                    |                             |              |            | 1  |                | of What Cou                 | untry?   |  |
|            | s 236  | Funeral  | 2405 Wildflowe  |  | t Francis II C         | 10.1                    |                             | 20639                       |              | -:-0 (0    | -4   | U.S            |                             |  |  |
| 40         | her d  | FL   | 11. Marital Status  1 ☐ Never Married 2 ☐ Marri   | 12. Was Deceder<br>Armed Forces<br>ed 1 ☐ Yes 2 ☑  | ?                      | . 13.                   | If Yes, spec                | ify Cuba                    | n, Mexican   | , Puerto   | cify Yes or No-<br>Rican, etc.)            | 14.            | Race - Amer<br>Black, White |  |  |
| 036        | al', o   | b  | 3 X Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates                      |                        |                         | 1 Yes 2                     | 2 <b>X</b> Ì No             | Specify:     |            |  | Sp             | ecify: Wh                   | ite  |  |
| 21215-0036 | 72 hours after death with the Maryland<br>natural; or itams 23a or 28a-1 show<br>deal Examiner mant be multied at  | eted   | 15. Decedent  |  |                        | 16a. Dece               | dent's Usua                 | l Occupa                    | ation        | of working | 20   | 16b. Kind      | of Business/l               | ndustry  |  |
| 21         | hen.   | npi  | Elementary/Secondary (0-12)   | 1  | r 5+)                  |                         |                             |                             |              |            | ,9   |                |                             |  |  |
| 2          | filed within<br>Hygiene.<br>Ither than "<br>int, the Med   |  |   | acti   |                        | Mail                    | Room                        | ı/Tin                       |              |            | (Fire Adidale                              |                |                             | ndustry  |  |
| Maryland   | 12 should be filed within h and Mental Hygiene. 7 is marked other than "traumatic avant, the Me.   | Be   |   |  |                        |                         |                             |                             |              |            |  |                | mame)                       |  |  |
| Z          | shoul<br>nd Me<br>mark   | F  |   |  |                        | 19b. Mailir             | ng Address                  | (Street a                   |              |            |  |                | own, State, Zi              | in Code)   |  |
|            | and 2<br>saith ai<br>n 27 is   |  | Paul Joseph Ea  | gan - Son  | 1                      |                         |                             |                             |              |            |  |                |                             |  |  |
| Baltimore, | of Health<br>of Health<br>litem 27 I   |  | 20a. Method of Disposition  | - 55   |                        | ce of Dispo             | sition (Nam                 | ne of                       |              |            | -  |                | ion - City or T             |  |  |
| Ë          | Pages<br>ment of h<br>ant: if its<br>ury or of   |  |   |  | e                      | -                       | •                           | -                           | · 1          | 12/1       | 4/2005                                     | Washi          | ngton.                      | DC   |  |
| Salt       | permit. Page<br>Department<br>Important: if<br>any injury o  | Mail Room/Time Keeper  17. Father's Name (First, Middle, Last)  John J. Bacigalupi  19a. Informant's Name/Relationship (Type, Print)  Paul Joseph Eagan — Son  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Catherine Smith  1 Service and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  Paul Joseph Eagan — Son  2 4 0 5 Wildflower Lane, Huntin tow  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  1 Signature of Date  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Address (Street and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Address (Street and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Address (Street and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Address (Street and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Address (Street and Number or Rural Route Number, City  2 Cotherine Smith  1 Service and Address of Facility Gasch's Function of Comments of Cother or Co |   |  |                        |                         |                             |                             |              |            |  |                | eral Home, P.A.             |  |  |
|            | 20 E E G   |  | Joung   | 11/4   |                        |                         |                             |                             |              |            | _  |                | ille, l                     |  |  |
|            |  | ,  | snocky, or neart failure. List  | complications/that cause<br>only one cause on each | od the death.<br>line. | Do not ent              | er the mode                 | e of dying                  | g, such as o | cardiac o  | r respiratory arre                         | est,           |                             | Approximate<br>Interval Between<br>Onset and Death |  |
|            | Physician<br>/Medical  |  | disease or condition  |  |                        |                         | <b>i</b> a                  |                             |              |            |  |                |                             |  |  |
|            | Examiner   |  |   | Due to (or a                                       | s a conseque           | ince of):               |                             |                             |              |            |  |                |                             |  |  |
|            |  | ē  | Sequentially list conditions,  any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Oue to (or a                                    | в в сопводие           | nea of):                |                             |                             |              |            |  |                |                             |  |  |
|            | cuted<br>nd<br>ransit  | Examiner   | triat initiated events  | с.   |                        |                         |                             |                             |              |            |  |                |                             |  |  |
| ,<br>0,    | cate be executed obysician and the burial-transit  |  | resulting in death) Last  | Due to (or a                                       | s a conseque           | nce of):                |                             |                             |              |            |  |                |                             |  |  |
| 8760,      | The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit | Physician/Medical  |   | d  |                        |                         |                             |                             |              |            |  |                |                             |  |  |
| 9 xo       | death certifica<br>attending pt<br>of for use as t   | /Me  | IF FEMALE:  | 23c. If yes, outcom                                | e of pregnanc          | ·v                      |                             |                             |              |            |  |                |                             |  |  |
| Bo         | atten<br>I for u   | clan   | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live birth                                     | 2 ☐ Fetal d            | leath 3                 | Ectopic pre                 |                             |              |            |  | 230.           | Date of deliv<br>Month      | rery<br>Day Year                                   |  |
| 0          | at the de<br>by the a<br>tached  | hysi   | 1 Yes 2 No<br>9 Unknown   | 9□ Unknown   |                        |                         |                             |                             |              |            |  |                |                             |  |  |
| S, D       | es that<br>igned b   | by P   | Part II. Other significant conditio   | ns contributing to death                           | but not result         | ing in the u            | nderlying ca                | ause give                   | n in Part I. |            | 23e. Did tob                               | acco use       | contribute to t             | the cause of death?                                |  |
| ord        | w require<br>been sig<br>should b  | ted  |   |  |                        |                         |                             |                             |              |            | 1 ☐ Ye                                     | s 2 <b>∑</b> N | o 3∏Pro                     | bably 4 □Unknown                                   |  |
| Record     | e law r<br>has be<br>je 2 sh   | Completed  |   |  |                        |                         |                             |                             |              |            | 24a. Was an                                | 2              | 4b. Were auto               | opsy findings available ompletion of cause of      |  |
|            |  | Col  |   |  |                        |                         |                             |                             |              |            | perform<br>1 ☐ Yes 2                       |                | death?                      | 2 🗆 No   |  |
| Vital      | Physician:<br>this certific<br>ral director,   | Be   | 25. Was case referred to medical examiner?  | Hospital:  |                        |                         |                             | Otha                        |              |            | Check on one                               |                |                             |  |  |
| of         | Phys<br>this<br>ral dir  | 은  | 1 ☐ Yes 2 📉 No<br>27. Manner of Death   | 28a. Date of In                                    | ient 2 EF              | VOutpatien  8b. Time of |                             |                             | 4 K Nur      |            | ne 5 🗍 Reside<br>8d. Describe ho           |                |                             | fy)  |  |
|            | ding f<br>h.<br>After<br>funer   | tion   | 1 XNatural 5 ☐ Pending<br>2 ☐ Accident investig   | (Month, D  | ay Year)               | Injury                  | M                           | Bc. Injury<br>Work<br>1 □ Y | ?<br>′es 2⊡N |            | ou. Describe no                            | w injury oc    | curred                      |  |  |
| Division   | or Attending<br>after death.<br>Director: Aftei<br>in by the fune  | flca   | 3 ☐ Suicide 6 ☐ Could n   | ot be 28e. Place of Ir                             | njury - At hom         | e, farm, str            |                             |                             |              |            |  |                | um <i>ber or Run</i>        | al Route Number,                                   |  |
| ā          | in the d   | Certification;   | 4 Homicide determi  | building, e  | etc. (Specify)         |                         |                             |                             |              |            | City or Town                               | , State)       |                             |  |  |
|            | • Hospital<br>124 hours a<br>• Funaral C<br>letely filled  | edical (   | 29a. Certifier (Check only 21 Medical 8   | Physician: To the bes                              | t of my knowle         | edge, death             | occurred a                  | at the time                 | e, date and  | place, a   | nd due to the ca                           | use(s) and     | l manner as s               | stated.  |  |
|            | To the Hospitai<br>within 24 hours a<br>To the Funaral I<br>completely filled  | Medi   | One)  | and manner s                                       | stated.                |                         |                             |                             |              |            |  |                |                             |  |  |
|            | or will  | ~  | 29b. Signature and title of certifie  |  |                        |                         | 29c.                        | License                     | number       | ic.        | 25   | d. Date si     | gned (Month,                | Day, Year)   |  |
|            | (n)  |  | 20 Nema and 144 (   |  | M                      | 20/2                    | Deleti 4                    | 115                         | 199          | 7          |  | /              | 1101                        | <b>6</b> >   |  |
| R          |  |  | 30. Name and address of person v  | the completed cause of                             | DTA                    | sa) (Type,              | Post Contract of the second | Su                          | ite          | 3/0        | Do   | nce f          | Epolo.                      | -16 MD   |  |
|            | Sta  | ite  | 31. Date filed (Month, Day, Year)   | 2. Regis   | trar's Signatur        | re 🖍                    | -01                         | 100                         |              | //         | 1.   | 100            | CUU                         | 12.0678  |  |
|            | Registr  | rar  | DEC 142   | 005 Kleina   | 18                     | April                   |                             |                             |              |            |  |                |                             | 20070  |  |

|                   |  |                | For<br>State<br>Registrar  | State of Maryla   |                                     | artment of H   |   | Re                                     | eg. No.  | 42289   |
|-------------------|--|----------------|--|---|-------------------------------------|--|---|--|--|---|
| 4                 | Physicia<br>/Medic   |                | 1. Decedent's Name (First, Middle, Last, Ruth Vess Flet  |   |                                     |  |   | 2. Date of Deat<br>Month<br>December   | Day Year   | 3. Time of Death                                |
| )                 | /Medic<br>Examin   | 95.3           | 4a. Facility Name (If not institution, give<br>Prince George's   | street and number)  | ter                                 | 4b. City, Town, or<br>Chev                                       |   |  | 4c. County of Death                              | 1   |
| ,35               | Funeral<br>Director  |                | 5. Social Security Number 6. Sec. 1579–34–7923   |   | rs. last birthday)<br>Yrs.          | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs.<br>Hours Min.                                  | 8. Date of Birth (Month, Day, 1/26/2   |  | nplace (State or Foreign<br>untry)<br>Virginia  |
|                   | show   | J.             | Usual Residence of Decedent  10a. State 10b. County  | 10c.  | City, Town or L                     |  |   |  |  | 10d. fnside City Limits 1 ☐ Yes 2 ☐ No          |
|                   | with the M<br>s or 28a-f   | Director       | D.C.  10e. Street and Number   |   | Washin                              | 10f. Zip Code  | 00040   | 1                                      | 0g. Citizen of What Co                           | untry?  |
| 320               | hours after death with the Maryland<br>turet', or items 23a or 28a-f show<br>a Exertinativant be notified at   | by Funeral     | 4921 Fitch Place  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: | U.S. 13.                            | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🔀 No      | 20019<br>ispanic Origin? (Sp<br>in, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)       |  | ncan Indian,                                    |
| -6121             | within 72<br>ane.<br>then "nat   | Completed      | 15. Decedent's Edu<br>(Specify only highest grad   | cation<br>e completed)<br>College (1-4or 5+)  | (Give                               | dent's Usuaf Occup<br>kind of work done of<br>DO NOT use retired | during most of work   | ing                                    | 16b. Kind of Business/                           | Industry  |
| Maryiand 2        |  | To Be Co       | 12th 17. Father's Name (First, Middle, Last) Junious Vess  | 0.00  |                                     |  | 18. Mother's Name   | nderson                                | Maiden Sumame)                                   |   |
|                   | s 1 and 2 should<br>f Health and Mer<br>item 27 Is marke<br>other traumatic  |                | 19a. Informant's Name/Relationship (T) Keith Fletcher/Sc   | n   | 1050                                | 5 Vista G  | ardens Di   | .,Bowie                                |  | )   |
| Baltimore,        | permit. Pages 1 ar<br>Department of Hea<br>Important: If item<br>eny injury or othe<br>once.   |                | 20a. Method of Disposition  1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify,  | Removal from State  | Harmony                             | osition (Name of matory or other place Par                       | k 12/2  |  | 20c. Location - City or Landover                 |   |
| Бап               | Departi<br>Departi<br>Import<br>eny inj  |                | 21. Signature of Funeral Service Licens  Any W.  23a. Partl. Enter the disease, or comp  | OATT  | _                                   |  | ington &  |  |  | o.C.20019                                       |
|                   | Physician<br>/Medical<br>Examiner  |                | snock, or near tailure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | a. Urose  Due to (or as a const   | en 51.                              |  |   |  | est,   | Approximate Interval Between Onset and Death    |
| 8760,             | cate be executed oblysicien and the burial-transit   | dical Examiner | Sequentially hist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a const.  Due to (or as a const.  |                                     |  |   |  |  |   |
| .O. Box 6         | Attending Physician: The law requires that the death certificat reads.  r death.  sctor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the structure of | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ ₩6 9 □ Unknown  | 23c. If yes, outcome of pre<br>1 Live birth 2 F<br>4 Pregnant at time of<br>9 Unknown         | etal death 3                        | □Ectopic pregnancy<br>□ Other (specify)                          | ′   |  | 23d. Date of deli<br>Month                       | ivery<br>Day Year                               |
| ۵.                | quires that<br>n signed b<br>utd be deta   | ed by Pl       | Part fl. Other significant conditions co   |   | ,                                   |  |   |  | bacco use contribute lo<br>es 2 ⊠No 3 □ Pr       | the cause of death?                             |
| Records,          | The law requir<br>te has been si<br>age 2 should I   | Completed by   | Resourations<br>Diabets Mil  |   | Vent                                | ilator o   | Lependen  | 24a. Was a autops perform              | med? prior to death?                             | topsy findings available completion of cause of |
| Vital             | ician: '<br>certifica<br>rector, p   | Be             | 25. Was case referred to medical examiner?   | Honoitat /  |                                     | Oth  | 26. Place of Deat   | h (Check only or                       | Pe)  |   |
| Division of Vital | nding Physician: The lavath.<br>r: After this certificate has<br>te funeral director, page 2   | ation: To      | 1 Yes 2 10  27. Manner of Death 1 12 Natural 5 Pending 2 Accident Investigation  | 28a. Date of fnjury<br>(Month, Day Year   | 28b. Time<br>28b. Time<br>Injury    | of 28c. Injur<br>Wor   | y at k? Yes 2□No  |  | ence 6 Other (Specow injury occurred             | cify)   |
| Divis             | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Pface of Injury - A building, etc. (Sp   |                                     | treet, factory, office   |   | 28f. Location (S.<br>City or Town      | treet and Number or Ru<br>n, State)              | iral Route Number,                              |
|                   | To the Hospital or within 24 hours afte To the Funeral Director completely filled in the Funeral Director of the Funeral Direc | edical         | 29a. Certifier 1 Certifying Phy<br>(Check only 2 Medical Examone)  | ysician: To the best of my<br>iner: On the basis of exan<br>and manner stated.                | knowledge, dea<br>nination and/or i | th occurred at the tir<br>nvestigation, in my d                  | me, date and place,<br>ppinion, death occur                     | and due to the c<br>red at the time, d | ause(s) and manner as<br>late and place, and due | stated.<br>to the cause(s)                      |
|                   | To the within 2 To the complet   | Ň              | 29b. Signature and title of certifier  | leibra  | J.                                  | 29c. Licens  | o number 2 / 8 / 2  | _ 2                                    | 9d. Date signed (Mont)                           | n, Day, Year)                                   |
| -                 |  |                | 30. Name and address of person who of PAULA DE VUE   | completed cause of death (  | Item 23a) (Type                     | Print)   | ed Hya  | 450.1k                                 | DECEMBER  M ZO                                   | 78  |
|                   | St<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year) DEC 1 6 2005   | 2. Registrar's S  | ignature.                           | æ.   |   |  |  |   |

|                     |   |                | 1 = For<br>State<br>Registrar                                   | State of                          | Marylan                      |                        | artment o                            |                            |                 | ental Hyg                           | iene<br>200            | 15         | 1,22  | 90        |
|---------------------|---|----------------|---|-----------------------------------|------------------------------|------------------------|--------------------------------------|----------------------------|-----------------|-------------------------------------|------------------------|------------|---|-----------|
|                     |   |                | Decedent's Name (First, Midd                                    | le, Last)                         |                              |                        |                                      |                            |                 | 2. Date of Deat                     | h                      |            | 3. Time of                                  | Death     |
|                     | Physici<br>/Medio   |                | Dona1d  | Louis                             |                              | Fra                    | tino                                 |                            |                 | Month<br>Decembei                   | Day 11 20              | Year<br>05 | 0840  | М         |
|                     | Examir  |                | 4a. Facility Name (If not institution                           |                                   | er)                          |                        |                                      | n, or Location             |                 |                                     | 4c. County             |            |   |           |
|                     |   |                | Anne Arundel  | Medical Cer                       | iter                         |                        | Ann                                  | apolis                     |                 |                                     | Anne                   | Aru        | nde1  |           |
|                     | Funeral   |                | 5. Social Security Number                                       |                                   | Age (In yrs. I               | ast birthday)          | If Under 1 Ye                        | ar If Under                | 24 Hrs.<br>Min. | 8. Date of Birth<br>(Month, Day,    |                        |            | place (State o                              | r Foreign |
|                     | Director  |                | 220-28-0867   | 1 XM 2□ F                         | 74                           | Yrs.                   | Months                               | lys Hours                  |                 | June 6,                             | 1931                   |            | nectic                                      |           |
|                     | and w   |                | Usual Residence of Decedent  10a. State 10b. County             | ,                                 | 10c Cin                      | , Town or Lo           | veation                              |                            |                 |                                     |                        |            | 104 (14- 0)                                 |           |
|                     | Aaryli<br>F sho   | ō              |   | Arunde1                           |                              |                        |                                      |                            |                 |                                     |                        |            | 10d. Inside Cit<br>1 ☐ Yes                  |           |
|                     | 28a-  | Director       | 10e. Street and Number  | Arunder                           | Gail                         | nbrill:                | S 10f. Zip Cod                       | lo.                        |                 | 1/                                  | 3= Ciri(1)             | 1/1-1-0-   |   | -26_110   |
|                     | with<br>la or   | ā              | 2024 Huntclif   | f Drive                           |                              |                        | 210                                  |                            |                 | "                                   | Og. Citizen of V       |            | intry?                                      |           |
|                     | hours after death with the Maryland<br>tural; or Items 23a or 28a-f show<br>A Exercit or Inval by Invitined at  | Funeral        | 11. Marital Status  | 12. Was Decede                    | ent Ever in U.               | S 13                   | Was Decedent                         |                            | inin2 /Sne      | ify Vas or No-                      | USA<br>14 Bac          |            | ican Indian,                                |           |
| (0                  | riter   | Fun            | 1 ☐ Never Married 2 💥 Mar                                       | Armed Force                       | es?                          |                        | If Yes, specify C                    | uban, Mexicar              | n, Puerto F     | Rican, etc.)                        |                        | k, White   |   |           |
| 93                  | eal', o   | þ              | 3 ☐ Widowed 4 ☐ Divorced  | If Yes Give                       | _<br>s: 1954 <b>-</b>        | -56                    | 1□Yes 2∏X1                           | No Specify:                |                 |                                     | Specify                | . Wh       | ite   |           |
| 2-0                 | d within 72 hours after death with the Marylan<br>giene.<br>ir than "natural", or Items 23a or 28a-f show<br>It e Medical Exacited for at ke neithed at | Completed      | 15. Deceder   | nt's Education                    |                              |                        | dent's Usual Oc                      |                            | 4 - 4           | _ 1                                 | 6b. Kind of Bu         | ısiness/lı | ndustry                                     |           |
| 2                   | within ene.   | nple           | Elementary/Secondary (0-12)                                     | College (1-4                      | or 5+)                       | life.                  | kind of work do<br>DO NOT use re     | tired)                     | st of workin    | g                                   |                        |            |   |           |
| 7                   | e filed within<br>al Hygiene.<br>other than<br>vent, the Me   | Co             |   | 5+                                |                              | _Atto                  | rney/Ju                              | dge                        |                 |                                     | Lega1                  |            |   |           |
| 밀                   | D # D .   | Be             | 17. Father's Name (First, Middle,                               |                                   |                              |                        |                                      |                            |                 | (First, Middle, M                   |                        | ю)         |   |           |
| 3                   | should be<br>ind Menta<br>imarked<br>imatic ev  | ဥ              | Donald James  |                                   |                              |                        |                                      |                            |                 | Jackson                             |                        |            |   |           |
| Maryland 21215-0036 | 0 6 6 6   |                | 19a. Informant's Name/Relations                                 |                                   |                              | 1                      |                                      |                            |                 | Route Number,                       |                        |            |   |           |
|                     | s 1 and 2<br>of Health<br>Item 27 other tre   |                | Mary M. Frati   | no (Wife)                         | OOL DI                       |                        |                                      |                            |                 | Gambrill                            |                        |            |   |           |
| Baltimore,          | Pages hent of Hent He   |                | 20a. Method of Disposition<br>1X Burial 2 ☐ Cremation           | 3 Removal from Sta                | ate 200. Pi                  | ace of Dispo           | sition (Name of<br>natory or other p | place)                     | Da              | ate 2                               | Oc. Location -         | City or T  | own, State                                  |           |
| Ë                   | t. Pa<br>tmen<br>tent:<br>ijury   |                | ' 4 ☐ Donation 5 ☐ Other (S                                     |                                   | Mar                          |                        | Vet. Ce                              |                            | 2-16-           | -2005                               | Crowns                 | vill       | e, MD                                       |           |
| Bal                 | permit. Pages<br>Department of<br>Importent: If I<br>any injury or<br>once.   |                | 21. Signature of Eugeral Service                                | Licensee                          | 11                           | 22                     | Name and Ad<br>Hardest               | dress of Facilit<br>V Fune | ral H           | Home, P.                            | Α.                     |            |   |           |
|                     | 40240   |                | On Part Franch disease 6  | ) ay                              |                              |                        | 12 Rids                              | gely Av                    | enue.           | Annapo                              | lis. M                 | 21         |   |           |
| М                   |   |                | 23a. Part1. Enter the disease, & shock, or heart failure. List  | only one cause on each            | h line.                      | , Do not ent           | er the mode of o                     | dying, such as             | cardiac or      | respiratory arre                    | st,                    |            | Approximate<br>Interval Betw<br>Onset and D | veen      |
|                     | Pnysician /<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death) | _ a/                              | 11/1/0                       | A CEM                  | bril                                 | 1100                       | 5000            | 499                                 |                        |            | 200)  | )         |
|                     | Examiner  |                |   | Due to (or                        | as a consequ                 | ience of):             |                                      | 3.16                       |                 | J                                   |                        |            | - /   |           |
|                     |   | er             | Sequentially list conditions.                                   | b. Due to (or                     | ас а соленом                 | ence or                |                                      |                            |                 |                                     |                        | -          |   |           |
|                     | uted<br>I<br>Insit  |                | cause. Enter Underlying<br>Cause (Disease or injury             |                                   |                              |                        |                                      |                            |                 |                                     |                        |            |   |           |
| Ć,                  | execting and in and in all-tra  | Examin         | that initiated events<br>resulting in death) Last               | c. Due to (or                     | as a consequ                 | ence of):              |                                      |                            |                 |                                     |                        | -          |   |           |
| 8760,               | cate be executed<br>physician and<br>the burial-transit   | dical          |   | d                                 |                              |                        |                                      |                            |                 |                                     |                        |            |   |           |
| 9                   | tificat<br>19 ph)<br>as th  | 0              |   |                                   |                              |                        |                                      |                            |                 |                                     |                        |            |   |           |
| Вох                 | death certific<br>e attending p<br>d for use as   | Physician/M    | IF FEMALE:<br>23b. Was decedent pregnant                        | 23c. If yes, outcor               | me of pregnar<br>1 2 ☐ Fetal |                        | Ectopic pregna                       | BOY                        |                 |                                     | 23d. Date              | e of deliv | ery   |           |
|                     | ed fo   | slcia          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                        |                                   | t at time of de              |                        | Other (specify)                      |                            |                 |                                     | Mor                    | ith        | Day Y                                       | ear       |
| P.0                 | that the de<br>led by the a<br>detached t   | Phy            | 9 Unknown   | 1                                 |                              |                        |                                      |                            |                 | 7                                   |                        |            |   |           |
| Ś                   | igi<br>bed  | þ              | Part II. Other significant condition                            | ons contributing to death         | h but not resu               | Iting in the ur        | nderlying cause                      | given in Part I.           |                 | 1                                   | acco use contr         | ibute to t | he cause of de                              | eath?     |
| Record              | w require<br>been si<br>should I  | ompleted       |   |                                   |                              |                        |                                      |                            |                 | 1 Tes                               | 2 12 No                | 3 Prot     | oably 4 ∏Ui                                 | nknown    |
| ec                  | elaw<br>hasb<br>ye2sh   | nple.          |   |                                   |                              |                        |                                      |                            |                 | 24a. Was an autopsy                 |                        | Vere auto  | opsy findings a                             | vailable  |
| <u> </u>            | Th<br>ate<br>pag  | Con            |   |                                   |                              |                        |                                      |                            |                 | perform                             | ed/ d                  | eath?      | 2□ No                                       |           |
| Vital               | icien: Th<br>certificate<br>rector, pag   | Be             | 25. Was case referred to medica examiner?                       |                                   |                              |                        |                                      |                            | of Death        | Check only one                      | )                      |            |   |           |
| of                  | dir dir   | ပ္             | 1 Yes 2 No  | Hospital: 1 1 Inpa                |                              | R/Outpatien            | I JUDON                              |                            | rsing Hom       | e 5 🗆 Residen                       | ice 6 Othe             | ır (Specii | <i>(y)</i>                                  |           |
| E<br>0              | ding Ph<br>h.<br>After th<br>funeral  | lon            | 27. Manyler of Death 1 ☑ Natural 5 ☐ Pendir                     | 9                                 | njury<br>Day Year)           | 28b. Time of<br>Injury | 28c. In                              |                            |                 | 3d. Describe hov                    | v injury occurre       | ed         |   |           |
| Sic                 |   | cat            | 2 Accident investi 3 Suicide 6 Could                            | not be                            |                              |                        |                                      | Yes 2 1                    | -               |                                     |                        |            |   |           |
| Division            | l or Atten<br>after deatl<br>Director:<br>I in by the   | Certification: | 4 Homicide determ   | ined 289. Place of building,      | etc. (Specify)               | ne, tarm, stre         | et, factory, offic                   | CB                         | 28              | If. Location (Stre<br>City or Town, | et and Numbe<br>State) | er or Rura | al Route Numb                               | er,       |
| _                   | spitel  |                | 29a. Certifier 1P Certifyir                                     | ng Physician: To the be           | st of my know                | viedne death           | occurred at the                      | time data and              | d place, ar     | d due to the ear                    | rag(a) and mar         |            | teta d                                      |           |
|                     | e Ho  | edlcal         | (Check only 2 Medical one)                                      | Examiner: On the basis and manner | s or examinati               | on and/or inv          | estigation, in m                     | y opinion, deat            | th occurred     | d at the time, dat                  | e and place, a         | nd due to  | the cause(s)                                |           |
|                     | To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the  | Me             | 29b. Signature and title of certifie                            | 1                                 | -                            |                        | 29c. Lice                            | ense number                |                 | 290                                 | d. Date signed         | (Month,    | Day, Year)                                  |           |
|                     |   |                | D W   | Drovet 1                          | 20                           |                        | 1) 3                                 | 8445                       |                 |                                     | 12/12,                 | 126        | 05  |           |
|                     |   |                | 30. Name and address of person                                  | who completed cause o             | of death (Item               | 23a) (Type, I          | Pyrox)                               | 1.0                        |                 | $\cap$                              | 7                      |            | , h   |           |
|                     |   |                | 1 1 N   | Elegicia                          | 61                           | 30 1                   | 1(101/4)                             | y 17                       | VF)             | MAN                                 | epol13                 | 111        | 11  |           |
| 4                   | Sta   | -              | 31. Date filed (Month, Day, Year)                               | 32. Regi                          | strar's Signati              | иге                    | ,                                    | /                          | 7               |                                     |                        |            |   |           |
|                     | Registr   | al l           | Uh.U A  |                                   | Adm of                       | K - Ma                 | 0000                                 |                            |                 |                                     |                        |            |   |           |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Solveig Kathleen December 12, 1:15 a 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖫 F Director 1913 475-18-9377 92 Minnesota Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show 10d. Inside City Limits r then "naturel", or items 23a or 28a-f shov the Madical Experimer must be nutified at 1 ☐ Yes 2√ No Directo Maryland Prince George's Temple Hills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2929 Brinkley Road, #102 20748 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after I □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if Item 27 is marked other th any injury or other traumatic event, ITA once. 4 Program Coordinator National 4-H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Otto Austin Flom Cora Amelia Knutson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven Flom/ Nephew 2929 Brinkley Road, #102, Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State December 13 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2005 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Kichard Z Hales 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 18 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy jo Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2/1No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2011 certificate 1 🗌 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: ٩ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MON 31. Date filed (Month, Day, Year) DEC 15 3. Registrar's Signature State 2005 Registrar

| 1400  |                     | 1 = For State Registrar  | State of Maryla  |                                    |  | of Health and<br>of Death                        | •                                      | giene<br>Reg. N2 () (              | 05                           | 42292  |
|---|---------------------|--|--|------------------------------------|--|--|--|------------------------------------|------------------------------|--|
| Physic<br>/Med  |                     | Decedent's Name (First, Middle, La     Archie Lee Finace   | gin, Jr.   |                                    |  |  | 2. Date of De<br>Month<br>Decemb       | Day                                | Year 2005                    | 3. Time of Death 8:30P                             |
| Exam  |                     | 4a. Facility Name (If not institution, giver Anne Arundel Median   | · · · · · · · · · · · · · · · · · · ·  |                                    |  | wn, or Location of Dec<br>Dapolis                | ath                                    | 4c. Count                          | y of Death<br>Arund          | New York   |
| Funera<br>Directo   | _                   | 5. Social Security Number 6. S<br>578–18–9315  |  | s. last birthday<br>Yrs.           | ) If Under 1 Y   |  |  | th                                 | 9. Birthple<br>Count         | ace (State or Foreign                              |
| Maryland<br>a-f ehow  | tor                 | Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Arne   |  | City, Town or L                    | ocation<br>rewater   |  |  | -                                  | 10                           | d. Inside City Limits 1 ☐ Yes 2 🛣No                |
| with the  | Dire                | 10e. Street and Number 109 Stewart Drive   |  |                                    | 10f. Zip Co  |  |  | 10g. Citizen of                    | What Count                   | ry?  |
| faryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or fleme 23a or 28a-1 show aumatic event, the Medical Examiner must be marified at  | by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Ever in<br>Armed Forces?<br>1 XYes 2 □ No<br>If Yes, Give<br>Year or Dates: W W |                                    |  | of Hispanic Origin?<br>Cuban, Mexican, Pue       | Specify Yes or No<br>erto Rican, etc.) | USA<br>14. Ra<br>Bla<br>Specii     | ce - America<br>ck, White, e | tc.  |
| Maryland 21215-0036 of 2 should be filed within 72 hours att th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exert traumatic event, the Medical Exert.  | Completed           | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | lucation   | 16a. Dece<br>(Givenitie)           | edent's Usual C<br>e kind of work d<br>DO NOT use r<br>Captain | lone during most of w<br>etired)                 | orking                                 | 16b. Kind of B                     |                              |  |
| yland 2 buld be filed Mental Hygi arked other   | To Be Co            | 17. Father's Name (First, Middle, Last) Archie Lee   | _  | 44                                 |  | 18. Mother's N                                   | ame (First, Middle,<br>Louise          | Maiden Sumai<br>Ellen R            | me)<br>Rawling               | gs   |
| ore, No. 1 and of Health  |                     | 19a. Informant's Name/Relationship (  William B. Finagi  20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □                                    | n/ Brother 20b.  | 6 R                                | omar Dr  | r place)   | lis, Mary<br>Date                      | land 21<br>20c. Location           | 403<br>- City or Tov         | vn, State  |
| Baltimore, No permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tronce.  | la)                 | 4 Donation 5 Other (Specifical Sequiple Licer  | ,) K   | 2                                  | remator<br>2. Name and A<br>2973 So                            | y   12-<br>ddress of Facility (<br>10mons Is     | -23-05<br>George P.<br>Land Rd.        | Edgewa<br>Kalas<br>Edgewat         | Funera                       | al Home  |
| Physician<br>/Medica<br>Examine   |                     | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | one cause on each line.  | exace                              | er bat   |  | ac or respiratory ai                   | rest,                              |                              | Approximate<br>Interval Between<br>Onset and Death |
| 8760, Cale be executed physicien and the burial-transit   | ical Examiner       | Sequentially list conditions, if any conditions are cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Drue to (or as a consect.  Due to (or as a consect.)  Due to (or as a consect.)                  |                                    |  |  |  |                                    |                              |  |
| Division of Vital Records, P.O. Box 68760, To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of preg<br>1   Live birth 2   Fe<br>4   Pregnant at time of<br>9   Unknown  | tal death 3 l                      | □Ectopic pregn   |  |  |                                    | ate of deliver               | y<br>Day Year                                      |
| cords, P  | þ                   | Part II. Other significant conditions of   | ontributing to death but not re  | sulting in the t                   | underlying caus  | e given in Part I.                               | 23e. Did to                            | obacco use con                     |                              | cause of death?                                    |
| Division of Vital Records, to Attending Physician: The law requires the death. Director: Aller this certificate has been signed in by the funeral director, page 2 should be considered.  | Completed           |  | , 0  |                                    |  |  | 24a. Was<br>autop<br>perfo<br>1  Yes   | rmed?                              | death?                       | sy findings available pletion of cause of          |
| oysician:   | To Be               | 25. Was case referred to medical examiner? 1 🗀 Yes 2 📉 o   | Hospital: 1 Minpatient 2[  | ☐ ER/Outpatie                      | nt 3□ DOA  | Other  | eath Check only o                      |                                    | ner (Specify)                |  |
| ision of  | ertification:       | 27. Manner of Death  Natural 5 Pending 2 Accident investigation  |  | 28b. Time of Injury                |  | Injury at Work?                                  | 28d. Describe h                        |                                    |                              |  |
| Division Ital or Attentors after deat rel Directors led in by the   | O                   | 3 Suicide 6 Could not be determined  | building, etc. (Spec   | eify)                              |  |  | 28f. Location (S<br>City or Tow        | vn, State)                         |                              |  |
| Div<br>To the Hoepital or A<br>within 24 hours after<br>To the Funerel Dires<br>completely filled in by   | edical              | 29a. Certifier (Chack only one) Certifying Ph  | ysicien: To the best of my kr<br>iner. On the basis of examir<br>and manner stated.              | nowledge, deal<br>nation and/or in | th occurred at the<br>evestigation, in i                       | ne time, date and place<br>my opinion, death occ | e, and due to the curred at the time,  | cause(s) and ma<br>date and place, | anner as sta<br>and due to t | ted.<br>he cause(s)                                |
| To th<br>within<br>To th  | Me                  | 29b. Signature and title of certifier  | ) RQm,   |                                    | 29c. Lie   | 0 41816  |  | 29d. Date signe                    | d (Month, D                  | ay, Year)  |
| 15  |                     | 30. Name and address of person who charles with phal   | completed cause of death (Ite  | om 23a) (Type<br>010 5ala          | Print)   | slaved Rd.                                       | Annape                                 | li, MI                             | ) 2                          | 1401   |
| Si<br>Regis   | ate<br>trar         | 31. Date filed (Month, Day, Year)  | 32 egistrar's Sign   |                                    | aski j   |  |  |                                    |                              |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year 7.32 AM FERRERI DEC 2005 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **™** M 2□F Months Days Hours Yrs. 1924 218-14-0552 81 Oct 31, Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 No Baltimore Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 USA 7143 Rolling Bend Road #E 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify WII 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Technician 2+ Government 18. Mother's Name (First, Middle, Maiden Sumame) Unk 17. Father's Name (First, Middle, Last) Frank Ferreri Mollie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kimberly Ferreri (Daughter) 212 Bell Ringer Court, Newark DE 19702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Baltimore Nat'l Cem. 12/14/2005 Baltimore, MD uneral Service Licensee 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signatur 9013 Annapolis Road, Lanham, MD 20706 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) EARS RANSISTIONAL Due to (or as a consequence of): MONTHS TASTASIS ULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) HRONIC that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Inknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined Location (Street and Number or Rural Route Number, City, or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Box 68760. of Vital

The law requires that the death certificate be executed ed by the ettending physician a detached for use as the burial peen: this certificete hes or Attending Physician: funeral director, After death. the within 24 hours after deatl To the Funerel Director: Hospite

completely filled e L State Registrar

۾ Completed Be Certification: To in by t

Examiner Physician/Medical Medical

**Physician** 

/Medical

Examiner

Directo

Funerai

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Completed

Be

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**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28e-1 show other treumatic event, the Madical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. snt: If Item 27 is marked other than "natural", or Items 23

permit. Pages 1 Department of H Importent: If ite eny injury or ot once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0036

the Maryland

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Tes 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number

P19512

DEC - 11-2005

CATONS AVE BALTIMORE MD-21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900, SOUTH AKSHMI SAKTHIVEL NATHAN

31. Date filed (Month, Day, Year) DEC 1 2 2005 Registrar's Signature

MD

|                                | F<br>Di  | Physici<br>/Medic<br>Examir<br>uneral<br>rector  |
|--------------------------------|--|--|
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Denartment of Health and Mental Hydiene. | importent: if item 27 is marked other than "natural", or items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examinar must be notified at once. |
| مر                             | Phy<br>/M<br>Exa   | sician<br>edical<br>aminer   |
| °,                             | executed   | in and<br>ial-transit  |

1 - For State Registrar

|                     | P. Indiana   | 4              | Decedent's Name (First, Middle, Last)   |  |                    |  |  | Date of Death     Month                 | Day Year                       | 3. Time of Death                                |
|---------------------|--|----------------|---|--|--------------------|--|--|---|--------------------------------|---|
|                     | Physici<br>/Medi   |                | MARIA LEANDRA   | FUENTES DE                                   | ANDRAI             | )E                                       |  | 12                                      | 9 2005                         | 3:45p <sup>M</sup>                              |
|                     | Examir   |                | 4a. Facility Name (If not institution, give s                                 |  |                    |  | or Location of Deat                      | 1                                       | 4c. County of Deat             |   |
|                     |  |                | HOLY CROSS HOSPI  | TAT.   |                    | SILVER                                   | SPRING                                   |   | MONTGOMER                      | <b>XY</b>                                       |
| 8,                  | Funeral  |                | 5. Social Security Number 6. Sex  | 7. Age (In yr                                | s. last birthday)  |  |  | 8. Date of Birth<br>(Month, Day, Yo     | 9. Birt                        | hplace (State or Foreign untry)                 |
|                     | Director   |                | none 1  | M 2 <b>X</b> F                               | 75 Yrs.            | World Days                               | 110513                                   | 02/14/1                                 |                                | SALVADOR  |
|                     | 2  |                | Usual Residence of Decedent   |  | A: -               |  |  |   |                                | 404 1. 14. 00. 11. 5                            |
|                     | how  |                | 10a. State 10b. County  |  | City, Town or Lo   |  |  |   |                                | 10d. Inside City Limits                         |
|                     | a-f-   | Director       | MARYLAND MONTGOMER  | Y KEN  | NSINGTON           | <b>.</b>                                 |  |   |                                | 1 ▼Yes 2 No                                     |
|                     | 17 28 E  | ire            | 10e. Street and Number  |  |                    | 10f. Zip Code                            |  | 10g                                     | . Citizen of What Co           | ountry?   |
|                     | h wii  |                | 3223 UNIVERSITY A   | VENUE  |                    | _ 2                                      | 0895                                     | E                                       | L SALVADO                      | R   |
|                     | s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Eventinal Mencollified at | Funeral        |   | 12. Was Decedent Ever in<br>Armed Forces?    | U.S. 13.           | Was Decedent of h                        | Hispanic Origin? (S<br>an, Mexican, Puer | pecify Yes or No-                       | 14. Race - Ame<br>Black, White |   |
| D                   | after<br>or It   | F              | 1 Never Married 2 Married   | 1 ☐ Yes 2 ☐ No<br>If Yes, Give               |                    | 1 Yes 2 No                               | ***                                      | L SALVADOR                              | Specify:                       | SPANIC  |
| 3                   | ral',  | by             | 3 Widowed 4 Divorced  | Year or Dates:                               |                    | 10 163 20 140                            | орвену.                                  |   | Specify.                       |   |
| ה<br>ה              | 72 ho  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade                            | cation<br>completed)                         | 16a. Dece          | dent's Usual Occup                       | pation<br>during most of wo              | rkina 16i                               | b. Kind of Business/           | Industry  |
| 7                   | within 72<br>ene.<br>than nai  | ple            | Elementary/Secondary (0-12)   | College (1-4or 5+)                           | life.              | DO NOT use retire                        | d)                                       | 9                                       |                                |   |
| 7                   | gien<br>gien   | NO.            | 2th   |  |                    | HOME MAK                                 |  |   | DOMESTIC                       |   |
| 3                   | be filed<br>tal Hygie<br>d other   | Be (           | 17. Father's Name (First, Middle, Last)                                       |  |                    |  | 18. Mother's Nar                         | ne (First, Middle, Ma.                  | den Sumame)                    |   |
| 0                   | Alenta<br>Alenta<br>Treed  | 10             |   | UNKNOW                                       |                    |  | FRANCIS                                  | CA FUENTES                              |                                |   |
| Maryland 21213-0036 | should<br>ind Men<br>ind marke<br>umaric   |                | 19a. Informant's Name/Relationship (Typ                                       | oe, Print)                                   | 19b. Maili         | ng Address (Street                       | and Number or Ru                         | ıral Route Number, C                    | ity or Town, State, 2          | Zip Code) <b>20895</b>                          |
|                     | and 2<br>ealth a<br>n 27 is  |                | MIRNA AYALA (d  | laugter)                                     | 3223               | UNIVERSI                                 | TY AVENU                                 | E WEST # 1                              | 1 Kensing                      | gton, MD.                                       |
| baiimore,           | permit. Pages 1 an Department of Heal importent: if item 2 eny injury or other once.   |                | 20a. Method of Disposition  |  | . Place of Dispo   | osition (Name of<br>matory or other pla  | ingl De-                                 | Date 24,05                              | c. Location - City or          | Town, State                                     |
| 2                   | Pages<br>nent of<br>nnt: if it   |                | 1 Surial 2 □ Cremation 3 □ Re<br>4 □ Donation 5 □ Other (Specify)             |  | •                  |  | ,  |   | n Miguel                       | El Salvado                                      |
|                     | it. P<br>rtme<br>rten<br>njur  |                | 21. Signature of Puneral Service Joseph                                       |  |                    | y:Jardine                                |  |   |                                | Funerarios                                      |
| 0                   | permit. Departr importe eny inje   |                | OX annually of  | 6 Pollot                                     |                    |  |  | W.:Washing                              |                                |   |
|                     | 23/12  |                | 23a. Part1. Enter the disease, or complic                                     | co gran                                      | -                  |  |  |   |                                | Approximate                                     |
|                     |  |                | shock, or heart failure. List only on   | e cause on each line.                        | ath. Do not en     | ter the mode of dy                       | rig, such as cardia                      | or respiratory arrest                   | ·                              | Interval Between<br>Onset and Death             |
|                     | Physician  |                | Immediate Cause (Final disease or condition                                   | SEVERE (                                     | CHRONIC            | OBSTRUCT                                 | CIVE                                     |   |                                |   |
| ŝ                   | /Medical   |                | resulting in death)   | Due to (or as a cons                         | equence of):       |  |  |   |                                |   |
|                     | Examiner   |                | Sequentially list conditions, b   | LUNG   | DISEASE            |  |  |   |                                | YRS   |
|                     | D =  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cons                         | ецивнов of).       |  |  |   |                                |   |
|                     | cuted  | E E            | that initiated events   |  |                    |  |  |   |                                |   |
| ĵ                   | an al  |                | resulting in death) Last  | Due to (or as a cons                         | equence of):       |  |  |   |                                |   |
| 0                   | ysicia<br>e bu   | cai            |   |  |                    |  |  |   |                                |   |
| 0                   | g ph<br>as th  | edi            |   |  |                    |  |  |   |                                |   |
| Box 68/60,          | leath certificate be executed<br>attending physician and<br>I for use as the burial-transit  | cian/Medical   | IF FEMALE: 23b. Was decedent pregnant 23                                      | 3c. If yes, outcome of pred                  |                    | 76                                       |  |   | 23d. Date of del               | ivery   |
| Ď                   |  | cia            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                      | 1☐Live birth 2☐Fi<br>4☐Pregnant at time o    |                    | ⊒Ectopic pregnanc<br>⊒ Other (specify) _ | :y                                       |   | Month                          | Day Year  |
| į.                  | the d<br>y the   | Physi          | 9 Unknown   | 9□ Unknown                                   |                    |  |  |   |                                |   |
| 7                   | The taw requires that the d<br>ste has been signed by the<br>page 2 should be detached   | P              | Part II. Other significant conditions con                                     | tributing to death but not i                 | resulting in the u | inderlying cause gr                      | ven in Part I.                           | 23e. Did tobac                          | co use contribute to           | the cause of death?                             |
| C                   | signe<br>d be  | d by           |   |  |                    |  |  | 1 ☐ Yes                                 | 2 □ No 3 □ Pr                  | obably <b>X</b> _Unknown                        |
| Ö                   | w requir<br>been si<br>should  | Completed      |   |  |                    |  |  | 04-146                                  | 041 144                        | A C   |
| 9                   | e taw<br>has l   | idiu           |   |  |                    |  |  | 24a. Was an autopsy performe            | prior to                       | topsy findings available completion of cause of |
| =                   |  | Ö              |   |  |                    |  |  |   |                                | 2□ No   |
| Vital Records,      | Physicien: The tribustens of this certificate har all director, page   | Be             | 25. Was case referred to medical examiner?                                    | I  |                    |  |  | ath Check only one                      |                                |   |
|                     | Physic<br>this o   | 2              | 1 ☐ Yes 2 🔀 No  | lospital: 1 🔀 Inpatient 2                    | ER/Outpatie        | III 3 DOA                                |  | lome 5 Residence                        | e 6 □Other (Spe                | cify)   |
| 0                   | ng Ph<br>ter th<br>neral   |                | 27. Manner of Death  1 Natural 5 Pending                                      | 28a. Date of Injury<br>(Month, Day Year)     | 28b. Time o        | of 28c. Inju                             | ry at<br>ork?                            | 28d. Describe how                       | injury occurred                |   |
| <u>o</u>            | Attending r death. ector: After by the fune  | atic           | 2 Accident investigation  |  |                    |  | ]Yes 2□No                                |   |                                |   |
| DIVISION OF         | ar de  | liff<br>of     | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - A building, etc. (Spe |                    | reet, factory, office                    |  | 28f. Location (Stree<br>City or Town, S | et and Number or Ru<br>State)  | ura! Route Number,                              |
| 5                   | s afte   | Certification: |   |  | 7/                 |  |  |   |                                |   |
|                     | To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | edical (       | (Check only 2 Medical Examir  | sician: To the best of my h                  |                    |  |  |   |                                |   |
|                     | thin 2<br>the<br>mplet   | Med            | 29b. Sign rate and title of certifier   | and manner stated.                           |                    | 29c. Licen                               | se number                                | 29d                                     | . Date signed (Mont            | h, Day, Year)                                   |
|                     | vith<br>To   |                |   | 0  | 0                  |  |  |   |                                |   |
| -                   |  |                | 4 Jau   | mpleted cause of death (I                    | 0                  | 0.50                                     | U487-                                    |   | 12-12-                         | <i>U</i> 5                                      |
| )                   | (2)  |                | 30. The and address of person who co  | empleted cause of death (I                   | tem 23a) (Type     | Print)                                   | ( no low                                 | 0000.                                   | ar mr                          | 20223   |
| -                   |  |                | AHMED NAWA  | 2110 10                                      | DUX S              | 5019                                     | MATH                                     | coes 1501                               | 24                             | 2000  |

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)
DEC 1 3 2005

| wrequires that the death certificate be executed wrequires that the death certificate be executed wrequires that the death certificate be executed wrequires that the death certificate be executed by the attending physicien and should be detached for use as the burial-transit control of the attending physicien and should be detached for use as the burial-transit control of the attending physicien and should be detached for use as the burial-transit control of the attending physicien and should be detached for use as the burial-transit control of the attending physicien and control of the attending | For State Registrar  Decedent's Name (First, Middle, Last)  Candice Lee Grift Facility Name (If not institution, give 907 Clarks Lane (If not institution) 907 Clarks Lane (If not institution) 908 11 909 12 909 12 909 12 909 12 909 12 909 12 909 12 909 12 909 12 909 12 909 13 909 14 909 15 909 16 | fin  street and number)  Apt. C  ax 7. Age  12. Was Decedent E Amed Forces? 1  | 22  10c. City, Tow Westmi  Ever in U.S.  10c. City Tow  10c. City  | Ab. City, 1 Bal Ithday) Yrs. If Under Yrs. Months  101. Zip 211  13. Was Decedif If Yes, specifit Yes, specific No NoT use erk  106. Kempf It Disposition (Nam ry, crematory or offin Y Cemete:  22. Name and Burrier 1212 W.  | Days Hours  Code  57  Jent of Hispanic Original Crify Cuban, Mexic | 2. Date of I Month Decem Death  Ly Hrs. 8. Date of 8 (Month, 12/16/  1 | Reg. No Death Day Der 1 4c.  Birth Day, Year) 1982  10g. Cit Unit No- 16b. Ki CONV I/e, Maiden n nber, City o , MD 20c. Lc NeW  | y year 4, 2005 County of Deat n/a 9. Birt 14. Race - Ame Black, Whit Specify: Wh. Cind of Business/ Venience or Town, State, 2 21074 ocation - City or Windsor   | hplace (State or Foreignand)  Land  10d. Inside City Limits  1 Tyres 2 No  nuntry?  es  rican Indian, e, etc. ite  Industry  Store  Zip Code)  Town, State  MD |
|--|--|--|--|--|--|--|---|--|--|
| Baltimore, Maryland 21215-0036  Baltimore, Maryland 21215-0036  Department of Health and Mental Hygiene.  Indicate and Ind | Candice Lee Griff Facility Name (If not institution, give 907 Clarks Lane A Social Security Number 6. Se 17-11-9885  ual Residence of Decedent a. State 10b. County D Carroll  e. Street and Number 6 Winchester Ave Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify only highest grace Elementary/Secondary (0-12) 0th Father's Name (First, Middle, Last)  OUG RUSSell a. Informant's Name/Relationship (Title Issa D. Solomo) a. Method of Disposition 1 Deurial 2 Cremation 3 4 Donation 5 Other (Specify Signature of Funeral Service Licenses)  Signature of Funeral Service Licenses  Gal. Part 1. Enter the disease, or composition of Cause (Final Sease or condition sulting in death)   | ## Street and number)  Apt. C    Apt. C   7. Age | 22  10c. City, Tow Westmi  Ever in U.S. 10  116a  17  20b. Place of cemete Bethar.  the death. Do e.   | thday)  If Under yrs.  In or Location  Inster  101. Zip 0  211  13. Was Decede If Yes, specifie Do NOT use the Control of the  | Town, or Location of Limore Cit 1 Year If Under 24 Days Hours  Code 57  dent of Hispanic Originality Cuban, Mexican, If Cocupation in the Company of the Park Its.  [Street and Number Field Dr. Inne of the place) 12.  Ind Address of Facility 12.  Ind Address of Facility 12.  Ind Address of Facility 12.  Ind Address of Facility 12.  Indiana Inne of Inne Inne of Inne Inne Inne Inne Inne Inne Inne Inn   | Month Decem  Death  Cy Hrs. 8 Date of E (Month, 12/16/   | Death Day Death | y Year 4, 2005 County of Deat n/a 9. Birt Co Mary  tizen of What Co ted State 14. Race - Ame Black, Whit Specify: Wh. Cind of Business/ Venience of Sumame)  or Town, State, 2 21074 ocation - City or Windsor | hhplace (State or Foreign untry)  land  10d. Inside City Limits  1 CYes 2 No nuntry?  es nican Indian, e, etc. ite Industry  Store  Zip Code)  Town, State  MD |
| Baltimore, Maryland 21215-0036  Benuire Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 1.12.  To Be Completed by Funeral Director 1.12.  To Be Completed by Funeral Director 2.23.  To  | Facility Name (If not institution, give 907 Clarks Lane A Social Security Number 6. Sec. 17-11-9885  ual Residence of Decedent a. State 10b. County Carroll b. Street and Number 6 Winchester Ave Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edic (Specify only highest grace Elementary/Secondary (0-12) 0th Father's Name (First, Middle, Last)  COUG RUSSELL b. Solomol a. Method of Disposition 120 Burial 2 Cremation 3 Method of Disposition 120 Burial 2 Cremation 3 Signature of Funeral Service Licenses of Condition Sulting in death)   | Apt. C    Apt. C   7. Age     Apt. C   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 2 XF   7. Age     M 3 XF   7. Age     M 4 XF   7. Age     M 5 XF   7. Age     M 6 XF   7. Age     M 7 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 8 XF   7. Age     M 9 XF   7. Age     M 9 XF   7. Age     M 9 XF   7. Age     M 9 XF   7. Age     M 10 XF   7. A | 22  10c. City, Tow Westmi  Ever in U.S. 10  116a  17  20b. Place of cemete Bethar.  the death. Do e.   | Balthday) If Under Yrs.  In or Location Inster  10f. Zip ( 211)  13. Was Decede If Yes. specifies kind of work iffe. DO NOT use erk  10 Kempf It Disposition (Nam ry, crematory or oth Y Cemete:  22. Name and Burrier 1212 W.   | Timore Cit  1 Year If Under 24 Days Hours  Code  57 Jent of Hispanic Originative City Cuban, Mexican, Individual Mexican, Indi | Deceming  1 Property  1 Proper | Jog. Cit Unit No-  16b. Ki CONV (le. Maiden n nber, City o New  | 4, 2005 County of Deat n/a 9. Birt Co Mary  tizen of What Co ted Stat 14. Race - Ame Black, White Specify: Wh. Cind of Business/ Venience of Sumame)  or Town, State, 2 21074 ocation - City of Windsor        | hhplace (State or Foreign untry)  land  10d. Inside City Limits  1 CYes 2 No nuntry?  es nican Indian, e, etc. ite Industry  Store  Zip Code)  Town, State  MD |
| Baltimore, Maryland 21215-0036  Bermit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Inportent: It item 27 is marked other than "natural; or items 23s or 28s-1 show transition of the strain of them 27 is marked other than "natural; or items 23s or 28s-1 show any fujury or other traumatic event, the Medical Expanding must be notified.  To Be Completed by Funeral Director.  To Be Completed by Funeral Director.  To Be Completed by Funeral Director.  | 907 Clarks Lane A Social Security Number 6. Se 17-11-9885  ual Residence of Decedent a. State 10b. County D Carroll  e. Street and Number  6 Winchester Ave Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12) 0th Father's Name (First, Middle, Last)  2000 Russell 2 Informant's Name/Relationship (7) 2 Information 5 Other (Specify Signature of Funeral Service Licenty Signature of Funeral Service Licenty Signature of Funeral Service Licenty Signature Cause (Final sease or condition sulting in death)  | Apt. C    Apt. C   7. Age     M 2   XF   7. Age     M 2   XF   7. Age     M 2   XF   7. Age     M 2   XF   7. Age     Armed Forces? 1   Yes 2   XF     If Yes, Give   Year or Dates:     Ucation   de completed     College (1-4or 5-4)     College (1 | 22  10c. City, Tow Westmi  Ever in U.S. 10  116a  17  20b. Place of cemete Bethar.  the death. Do e.   | Balthday) If Under Yrs.  In or Location Inster  10f. Zip ( 211)  13. Was Decede If Yes. specifies kind of work iffe. DO NOT use erk  10 Kempf It Disposition (Nam ry, crematory or oth Y Cemete:  22. Name and Burrier 1212 W.   | Timore Cit  1 Year If Under 24 Days Hours  Code  57 Jent of Hispanic Originative City Cuban, Mexican, Individual Mexican, Indi | Array (Specify Yes or Puerto Rican, etc.)  To working  To Rural Route Num  Hampstead  Date  /20/2005   | 10g. Cit Unit No- 16b. Ki Conv le, Maiden n nber, City o New  | n/a  9. Birtico Mary  tizen of What Co ted State 14. Race - Ame Black, White Specify: Wh.  Gind of Business/ Venience of Town, State, 2 21074 ocation - City of Windsor  | hplace (State or Foreignand)  Land  10d. Inside City Limits  1 Tyres 2 No  nuntry?  es  rican Indian, e, etc. ite  Industry  Store  Zip Code)  Town, State  MD |
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| Baltimore, Marylan, Bettimore,  Street and Number  6 Winchester Ave Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed. (Specify only highest grace Elementary/Secondary (0-12)  0th Father's Name (First, Middle, Last)  OUG RUSSELL  a. Informant's Name/Relationship (7)  [elissa D. Solomoi a. Method of Disposition  1 Deurial 2 Cremation 3 Deurial 2 Cremation 5 Other (Specify)  Signature of Funeral Service Licents  Ba. Part 1. Enter the disease, or composition of Cause (Final Sease or condition sulting in death)   | 12. Was Decedent E Armed Forces?  1  | the death. Do  | 10f. Zipe 211  13. Was Decede If Yes, specific Yes, specif | dent of Hispanic Originary  dent of Hispanic Originary  dent of Hispanic Originary  for Cuban, Mexican, Independent of the Company  18. Mother:  Melis:  (Street and Number Field Dr. Independent of the place)  ery 12,  Ind Address of Facility  | of working  s Name (First, Midd) sa Clinto or Rural Route Num Hampstead Date  /20/2005   | Unit  CONV  Je, Maiden  n  nber, City o  New  | ted State  14. Race - Ame Black, White Specify: Wh.  Cind of Business/ Venience of Surname)  or Town, State, 2 21074  ocation - City or  Windsor   | 1 Tyres 2 No untry?  es nican Indian, e, etc. ite Industry  Store  Zip Code)  Town, State  MD  |
| Baltimore, Marylan, Bettimore, rital Status    Marital Status   Never Married 2 Married 3 Widowed 4 Divorced   15. Decedent's Edi (Specify only highest grade State of Specify (0-12)   Marital State of Specify (1-12)   Method of Disposition   Method o  | 12. Was Decedent E Armed Forces?  1  | 192 192 20b. Place o cemete Bethar   | 211.  13. Was Deceded If Yes, specific Yes, specific Kend of word iffe. DO NOT use the Company of the Company o | dent of Hispanic Originary  dent of Hispanic Originary  dent of Hispanic Originary  for Cuban, Mexican, Independent of the Company  18. Mother:  Melis:  (Street and Number Field Dr. Independent of the place)  ery 12,  Ind Address of Facility  | of working  s Name (First, Midd) sa Clinto or Rural Route Num Hampstead Date  /20/2005   | Unit  CONV  Je, Maiden  n  nber, City o  New  | ted State  14. Race - Ame Black, White Specify: Wh.  Cind of Business/ Venience of Surname)  or Town, State, 2 21074  ocation - City or  Windsor   | es ncan Indian, e, etc. ite Industry  Store  Zip Code)  Town, State  MD  |
| Baltimore, Marylan, Bettimore, rital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)  Oth Father's Name (First, Middle, Last)  OUG RUSSELL  a. Informant's Name/Relationship (7)  [elissa D. Solomolia. Method of Disposition  1 Deurial 2 Cremation 3  4 Donation 5 Other (Specify)  Signature of Funeral Service Licentary  shock, or heart failure. List only comediate Cause (Final sease or condition sulting in death)  | 12. Was Decedent E Armed Forces?  1  | 192 192 20b. Place o cemete Bethar   | 13. Was Decede If Yes, special If Yes, special Image of Yes, speci | dent of Hispanic Original Cuban, Mexican, III.  22 No Specify:  al Occupation of doing most of the doing during most of the retired.  18. Mother:  Meliss  (Street and Number Field Dr. Interplace)  Ery 12,  Ind Address of Facility  | of working  s Name (First, Midd) sa Clinto or Rural Route Num Hampstead Date  /20/2005   | CONV le. Maiden n nber, City o New  | 14. Race - Ame<br>Black, White<br>Specify: Wh.<br>(ind of Business/<br>Zenience<br>of Sumame)<br>or Town, State, 2<br>21074<br>ocation - City or<br>Windsor  | ite ite industry  Store  Zip Code)  Town, State  |
| Baltimore, Marylan, Bettimore, Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ed.  (Specify only highest grace Elementary/Secondary (0-12) Oth  Father's Name (First, Middle, Last)  OUG RUSSELL  a. Informant's Name/Relationship (7)  (elissa D. Solomo)  a. Method of Disposition 1 Deurial 2 Cremation 3 4 Donation 5 Other (Specify  Signature of Funeral Service Licents)  Signature of Funeral Service Licents  a. Part 1. Enter the disease, or compandiate Cause (Final sease or condition sulting in death)   | Amed Forces?  1 Yes 2 No. If Yes, Give Year or Dates:  ucation de completed)  College (1-4or 5-4)  Type, Print)  In (Mother)  Removal from State  collications that caused one cause on each line  Narcotic  a. Narcotic   | 192 192 20b. Place o cemete Bethar   | If Yes, special of Yes, special of Yes, special of Yes, 2  Decedent's Usual (Give kind of work interpretation). Mailing Address of Yes, or Mailing Address of Yes, or Walling Address of Yes, or Yes,  | al Occupation rk done during most of se retired)  18. Mother's Meliss (Street and Number Field Dr. 1 ther place) ery  14. Address of Facility  | of working  s Name (First, Midd) sa Clinto or Rural Route Num Hampstead Date  /20/2005   | Convolle, Maiden  n  nber, City o  MD  20c. Lc  | Black, White Specify: Wh. Specify: Wh. Specify: Wh. Specify: Wh. Specify: Specify: Windsor Windsor   | e, etc. ite Industry  Store  Zip Code)  Town, State  MD  |
| Baltimore, Marylan, Bettimore, Widowed 4 Divorced  15. Decedent's Edi (Specify only highest grace) Elementary/Secondary (0-12) Oth Father's Name (First, Middle, Last) OUG RUSSELL  a. Informant's Name/Relationship (7) (elissa D. Solomo) a. Method of Disposition 1 Deurial 2 Cremation 3  4 Donation 5 Other (Specify) Signature of Funeral Service Licenses shock, or heart failure. List only comediate Cause (Final sease or condition sulting in death)   | If Yas, Give Year or Dates:  ucation  College (1-4or 5-4)  Type, Print)  In (Mother)  Removal from State  i)  see Specifications that caused one cause on each line  a. Narcotic   | 19t Cl 20b. Place o cemete Bethar  | Decedent's Usual (Give kind of word life. DO NOT use erk  D. Mailing Address  O. Mailing Address  O. Kempf  I Disposition (Namy, crematory or other company)  22. Name and Burrier  1212 W.  | 18. Mother:  18. Mother:  Melis: (Street and Number Field Dr. Inne of the place)  ery 12.  | s Name (First, Midd<br>sa Clinto<br>or Rural Route Num<br>Hampstead<br>Date<br>/20/2005  | Conv lle, Maiden n nber, City o , MD 20c. Lc  | renience or Town, State, 2 21074 ocation - City or   | Store  Zip Code)  Town, State  |
| Baltimore, Marylan, Bettimore, pecify only highest grade (Specify only highest grade) Oth Father's Name (First, Middle, Last) Oug Russell  a. Informant's Name/Relationship (Total Companies)  [Elissa D. Solomon  a. Method of Disposition  1208 urial 2 Cremation 3 Companies  4 Companies 5 Cother (Specify)  Signature of Funeral Service Licenty  shock, or heart failure. List only of mediate Cause (Final sease or condition sulting in death)  | College (1-4or 5-4  Type, Print)  n (Mother)  Removal from State  )  see Sications that caused one cause on each line  a. Narcotic   | 19th 177 20b. Place o comete Bethan  | (Give kind of work iffe. DO NOT use erk  D. Mailing Address (706 Kempf. f Disposition (Nam ry, crematory or other the company of the company  | 18. Mother:  Melis:  (Street and Number Field Dr. Interplace)  Ery 12,  Id Address of Facility   | s Name (First, Midd<br>sa Clinto<br>or Rural Route Num<br>Hampstead<br>Date<br>/20/2005  | Conv lle, Maiden n nber, City o , MD 20c. Lc  | venience or Town, State, 2 21074 ocation - City or Windsor   | Store  Zip Code)  Town, State  |
| Baltimore, Marylan, Bettimore, ementary/Secondary (0-12) 0th Father's Name (First, Middle, Last) DOUG RUSSELL  a. Informant's Name/Relationship (7 Ielissa D. Solomo) a. Method of Disposition 1 Deurial 2 Cremation 3 4 Donation 5 Other (Specify Signature of Funeral Service Licens  a. Part 1. Enter the disease, or compendate Cause (Final sease or condition sulting in death)   | College (1-4or 5-4)  Type, Print)  n (Mother)  Removal from State  ty)  see  | 19th 17 20b. Place o cemete Bethan   | o. Mailing Address 0. Mailing Address 0. Mailing Address 0. Kempf. of Disposition (Namry, crematory or off 1. Cemete. 22. Name and Burrier 1.212 W.  | 18. Mother's Meliss (Street and Number Field Dr. Inne of ther place) Ery 12, Ind Address of Facility   | s Name (First, Midd<br>sa Clinto<br>or Rural Route Num<br>Hampstead<br>Date<br>/20/2005  | n MD 20c. Lo  | or Town, State, 2 21074 ocation - City or Windsor  | Zip Code)<br>Town, State<br>MD   |
| Baltimore, Marylan, Bettimore, ther's Name (First, Middle, Last)  OUG RUSSELL  a. Informant's Name/Relationship (7  [elissa D. Solomo]  a. Method of Disposition  1 Deurial 2 Cremation 3 4  Donation 5 Other (Specify  Signature of Funeral Service Licent  shock, or heart failure. List only of mediate Cause (Final sease or condition sulting in death)  | Removal from State  Dications that caused one cause on each line  Narcotic   | 20b. Place o cemete Bethan   | Mailing Address 706 Kempf. If Disposition (Namry, crematory or other 122. Name and Burrier 1212 W.   | Meliss (Street and Number Field Dr. I ther place) Ery 12   | sa Clinto<br>or Rural Route Num<br>Hampstead<br>Date<br>/20/2005   | n MD 20c. Lo  | or Town, State, 2 21074 ocation - City or Windsor  | Zip Code)<br>Town, State<br>MD   |
| Baltimore, Marylan, Bettimore,  Informant's Name/Relationship (7) In Indiana D. Solomol  In Indiana D. Solomol  In Indiana 2 Cremation 3 The Indiana 2 Companion 5 The Indiana Signature of Funeral Service Licents  In Indiana D. Solomol  | Removal from State  Dications that caused one cause on each line  Narcotic   | 20b. Place o comete Bethan   | 706 Kempf.  f Disposition (Namny, crematory or other  ty Cemete:  22. Name and Burrier  1212 W.  | (Street and Number Field Dr. I   | or Rural Route Num<br>Hampstead<br>Date<br>/20/2005  | , MD<br>20c. Lo   | 21074<br>ocation - City or<br>Windsor  | Town, State  |
| Bakimore,  Bouted Department of Hea  Indian Items In Item  Items In Item  Solution of other care in Item  Caminer and Injury or other care in Items  Caminer and Item | In Informant's Name/Relationship (7) In Indiana D. Solomol  In Indiana D. Solomol  In Indiana 2 Cremation 3 The Indiana 2 Companion 5 The Indiana Signature of Funeral Service Licents  In Indiana D. Solomol  | Removal from State  Dications that caused one cause on each line  Narcotic   | 20b. Place o comete Bethan   | 706 Kempf.  f Disposition (Namny, crematory or other  ty Cemete:  22. Name and Burrier  1212 W.  | field Dr. I  | Hampstead Date /20/2005  | , MD<br>20c. Lo   | 21074<br>ocation - City or<br>Windsor  | Town, State  |
| Bakimore,  Bouted Department of Hea  Indian Items In Item  Items In Item  Solution of other care in Item  Caminer and Injury or other care in Items  Caminer and Item | a. Method of Disposition  1 Description   1 Description   2 Cremation   3 Description   4 Donation   5 Descrip | Removal from State  ()  See See See See See See See See See Se   | 20b. Place o comete Bethan   | f Disposition (Namry, crematory or other<br>ny Cemete:<br>22. Name and<br>Burrier<br>1212 W.   | ne of the place) 12, 2 ord Address of Facility   | Date /20/2005  | 20c. Lo   | ocation - City or<br>Windsor   | , MD   |
| Baltimo Baltimo Baltimo Baltimo Baltimo Bamir. Page Department of importent: if transit transit transit may follow or transit may follow or transit mainer.  | 1 Deurial 2 Cremation 3 4 Donation 5 Other (Specify Signature of Funeral Service Licens 3a. Part 1. Enter the disease, or composition shock, or heart failure. List only commediate Cause (Final sease or condition sulting in death)  | plications that caused one cause on each line  Narcotic  a. Narcotic   | Bethan   | 22. Name and<br>Burrier<br>1212 W.   | ery 12,  | /20/2005   | New   | Windsor  | , MD   |
| Physician /Medical Examiner  | Ba. Part1. Enter the disease, or compshock, or heart failure. List only dimediate Cause (Final sease or condition sulting in death)  | olications that caused one cause on each line  Narcotic  a   | the death. Do  | 22. Name and<br>Burrier<br>1212 W.   | d Address of Facility  |  |   |  |  |
| Physician /Medical Examiner  | Ba. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>mediate Cause (Final<br>sease or condition<br>sulting in death)  | olications that caused one cause on each line  | Θ.   | Burrier<br>1212 W.   | -Oueen Fúi<br>Old Libe   | neral Hom<br>rty Rd. W   | e and<br>infie  | Cremateld, MD  | ory,P.A.<br>21784  |
| Medical Examiner  penns is used that the state of the sta | shock, or heart failure. List only of<br>imediate Cause (Final<br>sease or condition<br>sulting in death)  | one cause on each line aNarcotic   | Θ.   |  |  | Ly IVIa IV   | T111-TC   | Ta vito  |  |
| /Medical Examiner  | mediate Cause (Final sease or condition sulting in death)  | a Narcotic   |  |  | e of dying, such as ca   | irdiac or respiratory  | arrest,   |  | Approximate<br>Interval Between  |
| Examiner  Delivery property pr |  | Due to (or as a  |  | ation  |  |  |   |  | Onset and Death  |
| trans  | annualistic the tips and distant   |  | a consequence  | of):   |  |  |   |  |  |
| trans  | equentially list conditions,<br>any, leading to immediate<br>use. Enter Underlying   | b. Due to (or as a   | a consequence  | of):   |  |  |   |  |  |
|  | at initiated events  | c  |  |  |  |  |   |  |  |
| cords, P.O. Box 6876  we requires that the death certificate by seen signed by the attending physic should be detached for use as the bolieted by Physician/Medica   | sulting in death) Last   | Due to (or as a  | a consequence  | of):   |  |  |   |  |  |
| w requires that the death certification is seen signed by the attending is should be detached for use as signed by Physician/Me  |  | . d  |  |  |  |  |   |  |  |
| coords, P.O. Bc we requires that the death we spen signed by the atter should be detached for use bleted by Physician  | FEMALE:  | 23c. If yes, outcome of  |  |  |  |  |   | 23d. Date of deli  | iverv  |
| wrequires that the wrequires that the s been signed by the s should be detached by Phys  | in the past 12 months?   | 1 ☐ Live birth 2<br>4 ☐ Pregnant at t  |  | 3 □Ectopic pre<br>5 □ Other (spe   |  |  |   | Month  | Day Year   |
| cords, we require the speed speed should be de should be de speed speed by I   | 9 Unknown  | 9□ Unknown   |  |  |  |  |   |  |  |
| aw requires s been s should  | rt II. Other significant conditions co<br>Cirrhosis of Liver   | ontributing to death bu  | it not resulting i   | n the underlying ca  | ause given in Part I.  |  |   | use contribute to  | the cause of death?  |
| 0 2 00 0   |  |  |  |  |  |  |   |  | - //   |
| The la   |  |  |  |  |  | , pe   | topsy<br>rformed?   | prior to death?  | topsy findings available<br>completion of cause of   |
| Vital F siclen: Th certificate riector, pag SBe Co   | . Was case referred to medical   |  |  |  | 26. Place o  | 1 X Yes<br>I Death (Check only   |   | 1 🔼 Yes  | 2□ No  |
| Physicie this cert al direct   | examiner?<br>1 ☐ Yes 2 ☐ No  | Hospital: 1   Inpatier   |  | utpatient 3 DO   | OA Other: 4 Nurs   | ing Home 5□Re  | sidence   | 6 <b>√∑</b> ther (Spec   | oly) scene   |
| Ading P Alter t funeral funera | Manner of Death t □Natural 5 □ Pending   | Pla Date of Injury   |  | 1.4  | 8c. Injury at<br>Work?<br>1 ☐ Yes 2 🛣 No   | 28d. Describ   | e how injur   | ry occurred  |  |
| Division C<br>rs after death.<br>st after death.<br>ed in by the funers<br>Certification:  | 2 Accident investigation 3 Suicide 6 Could not be  | 12/13/03   | 2:00<br>ary - At home, fa  | P Marm, street, factory,   |  | UK   | (Street an  | nd Number or Ru  | ıral Route Number,   |
| Div.   | 4 Homicide determined  | building, etc.   | n apartme  |  |  | Apt C I  | 'own, State   | a) 3007 (1   | arks Lane  |
| Divisio  To the Hospital or Attendiwithin 24 hours after death. To the Funeral Director: A completely filled in by the table Medical Certification.  | Da. Certifier 1 Certifying Phy<br>(Check only 27 Medical Exam  | ysician: To the best on the basis of   | of my knowledge  | e, death occurred a  | at the time, date and  | place, and due to th   | e cause(s)  | ) and manner as  | stated.  |
| the H<br>thin 24<br>the F<br>mplete  | one)  b. Signature and title of certifier  | and manner stat  | ted.   |  | . License number   |  |   | ite signed (Monti  | •  |
|  | Signature and the or certifier   | mi   |  |  |  |  |   |  |  |
| W 50 30.   | r mi h   | 1  | noth (Itom 22a)  |  | CME  |  | Dece  | ember 15   | ), 400J  |
|  | . Name and address of person who c   | completed cause of de  | Bath (Item 23a)  | (Type, Funt)   |  |  |   |  |  |
| State 31.<br>Registrar   |  | 111 Penn S   |  |  | e, Marylar   | nd 21201   |   |  |  |

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Iteme 23a or 28e-f ehow eny injury or other traumatic event, the Madical Examiner must be nutilised at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0036

|  | ype or Prin   | t in Blacl                        | k Indeli                               | ble Ink. Ens   | ure All C                          | opies Ar                           | e Legible                             |   |
|--|---|-----------------------------------|--|--|------------------------------------|------------------------------------|---------------------------------------|---|
| reer<br><b>1</b> = For<br>State<br>Registrar   | State of Ma   | •                                 | •                                      | ent of Health<br>cate of Deatl                                 |                                    | ntal Hygie<br>Reg.                 | 2000                                  | 42297                                   |
| 1. Decedent's Name (First, Middle, Last)   |   |                                   |  |  |                                    | Date of Death<br>Month             | Day Yea                               | 3. Time of Death                        |
| RONALD CURRY GREEN   | R   |                                   |  |  |                                    | cember                             | 10. 200                               | M                                       |
| 4a. Facility Name (If not institution, give  |   |                                   | 4b.                                    | City, Town, or Location  |                                    |                                    | 4c. County of De                      |   |
| Easton Memorial Ho   | 1   | (In yrs. last birt                | thday) If L                            |  | er 24 Hrs. 8.                      | Date of Birth                      | Talbot 9. E                           | irthplace (State or Foreign             |
|  | M 2□F   | 48                                | Yrs. Mor                               | iths Days Hours  | Min.                               | (Month, Day, Ye                    | 1956 M                                | Country)                                |
| 10a. State 10b. County   |   | 10c. City, Town                   | n or Location                          |  |                                    |                                    |                                       | 10d. Inside City Limits 1 ☐ Yes 2 🕱 No  |
| MD QUEEN A   | NNE'S   | STEVE                             | INSVIL                                 |  |                                    |                                    |                                       |   |
| 10e. Street and Number   |   |                                   | 10                                     | f. Zip Code  |                                    |                                    | Citizen of What                       | Country?                                |
| 211 QUEEN ANNE ROA   | AD  |                                   |  | 21666  |                                    |                                    | USA                                   |   |
| 11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced                  | 12. Was Decedent B<br>Armed Forces?<br>1 MYes 2 □ N<br>If Yes, Give<br>Year or Dates: |                                   | If Yes                                 | Decedent of Hispanic Conspecify Cuban, Mexicons 2 X No Specify | an, Puerto Rica                    | Yes or No-<br>an, etc.)            | 14. Race - Ar<br>Black, W<br>Specify: | merican Indian,<br>hite, etc.<br>WHITE  |
| 15. Decedent's Edu<br>(Specify only highest grad   | e completed)  |                                   | Decedent's<br>(Give kind<br>life. DO N | Usual Occupation of work done during me<br>OT use retired)     | ost of working                     | 161                                | b. Kind of Busines                    | ss/Industry                             |
| Elementary/Secondary (0-12)  | College (1-4or 5  |                                   | MER/O                                  | PERATOR  |                                    |                                    | RENTALS                               |   |
| 17. Father's Name (First, Middle, Last)  |   |                                   |  |  |                                    | rst, Middle, Mai                   | iden Sumame)                          |   |
| JOEL CURRY GREER,  |   | +Oh                               | Mailing Ad                             | dress (Street and Num  | AN IGLE                            |                                    | ity or Tourn State                    | Zin Code)                               |
| 19a. Informant's Name/Relationship (Ty   |   |                                   |  | · ·  |                                    |                                    |                                       | 21666                                   |
| SHELLY B. GREER/W  | LFE   | 20b. Place of                     |  | EN ANNE RD   | ., DIEV                            |                                    | c. Location - City                    |   |
| 20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify) |   | cemeter                           | ry, cremator                           | or other place)  | 12/14/2                            |                                    | revensvi)                             |   |
| 21. Signature of Funeral Service Licens  | - 21  | DIXONDO                           | 22. Nar                                | ne and Address of Fac  | ility                              |                                    |                                       | ·                                       |
| Managa   | ZIONO   | the                               | FELL<br>106                            | OWS, HELFE<br>SHAMROCK R                                       | URETH &                            | NEWNAM                             | I FUNERAL<br>MD 2161                  | HOME, P.A.                              |
| 23a. Part1. Enter the disease, or compl  | lications that caused   | he death. Do                      |  |  |                                    |                                    |                                       | Approximate<br>Interval Between         |
| shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition      | a He  | rosde                             | nti                                    | Cardio   | Vogcer (                           | ar D                               | bease                                 | Onset and Death                         |
| resulting in death)  | Due to (or as   | a consequence                     | of):                                   |  |                                    |                                    |                                       |   |
| Sequentially list conditions, if any, leading to immediate                                   | b. Due to (or as  | a consequence                     | of):                                   |  |                                    |                                    |                                       |   |
| cause. Enter Underlying<br>Cause (Diseese or injury  |   |                                   |  |  |                                    |                                    |                                       |   |
| that initiated events<br>resulting in death) Last  | C. Due to (or as  | a consequence                     | of):                                   |  |                                    |                                    |                                       |   |
|  | d   |                                   |  |  |                                    |                                    |                                       |   |
| 220  |   |                                   |  |  |                                    |                                    |                                       |   |
| IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown   | 23c. If yes, outcome<br>1□Live birth<br>4□Pregnant at<br>9□ Unknown                   | 2 Fetal death                     |  | pic pregnancy<br>ar (specify)                                  |                                    |                                    | 23d. Date of Month                    | delivery<br>Day Year                    |
| Part II. Other significant conditions co   | ntributing to death b   | ut not resulting i                | n the underh                           | ring cause given in Par  | rt I.                              | 23e. Did tobac                     | cco use contribute                    | to the cause of death?                  |
|  |   |                                   |  |  |                                    | 14 Yes                             | 2 □ No 3 □                            | Probably 4 Unknown                      |
|  |   |                                   |  |  |                                    | 24a. Was an                        | 24b. Were                             | autopsy findings available              |
|  |   |                                   |  |  |                                    | autopsy                            | d? death                              |   |
| 25. Was case referred to medical   |   |                                   |  | 26 Dis   | ice of Death /C                    | neck only one)                     | No 1                                  | 30 ZLINO                                |
| examiner?  | Hospital:<br>1 ☐ Inpatie  | int 2 ER/Ou                       | utpatient 3                            | Othor  |                                    |                                    | e 6 □Other (S                         | (pecify)                                |
| 27. Manner of Death  Natural 5 Pending   | 28a. Date of Inju<br>(Month, Da   |                                   | Time of<br>Injury                      | 28c. Injury at<br>Work?  | 28d                                | . Describe how                     |                                       | , |
| 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                      | 28e. Place of Inj<br>building, et   | ury - At home, fa<br>c. (Specify) |  |  |                                    | Location (Stree<br>City or Town, S |                                       | Rural Route Number,                     |
| (Check only 2 Medical Exam   | iner: On the basis of   | f examination ar                  | e, death occ                           | urred at the time, date  | and place, and<br>leath occurred a | due to the caus                    | se(s) and manner<br>and place, and c  | as stated.                              |
| one)   | and manner sta  | hote                              |  |  |                                    |                                    |                                       | to the cause(s)                         |
| 29b. Signature and title of certifier  | And manner sta  |                                   |  | 29c. License numbe   | )r                                 | 29d                                | . Date signed (Mo                     |   |

State Registrar

31. Date filed (Month, Day, Year)
DEC

DHMH 17 Rev 1/2001

ORIGINAL

11 Penn Street, Baltimore, Maryland 21201

who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11 2005 **Physician** DECEMBER GORDON R. 10:15A M CLARENCE /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S LARKIN CHASE NURSING HOME 8. Date of Birth Month, Pay, Year) 2/18/1924 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Min Days OHIO Country) Months 15∄M 2□F 81 Director 293-12-8995 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other treumatic event, Ite Madical Examiner was be rediffied at once. 1 Y es 2 □ No Director PRINCE GEORGE'S MD BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4311 HAMPTON LANE 20720 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT LAWYER 10 +17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL GORDON FRANCES PEOPLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY GORDON/WIFE 4311 HAMPTON LANE BOWIE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 12/19/2005 CHELTENHAM, MARYLAND MARYLAND VETERANS \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC ARRHYTHMIA Priysician /Medical Due to (or as a consequence of): **Examiner** CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se a consequence of Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FFMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐Yes 2☐No been signed by should be detact requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificate has page 2 1 Yes 28 No or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 4X Nursing Home 5. Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) After th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident the Director 6 Could not be determined 3 ☐ Suicid® Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homid To the Hospitel o within 24 hours aff To the Funerel Di completely filled in 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check or 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature title of certifier D57028 **DECEMBER 14, 2005** less of person who completed cause of death (Item 23a) (Type, Print) M.D. 600 RIDGELY AVENUE # 231 ANNAPOLIS, MARYLAND 21401 CHOPRA 31. Date filed (Month, Day, Year) 2. Registrar's Signature State DEC 1 6 2005 Registrar

|             |   |               | For   | State of Maryland                                    |                              |  |                                     | Mental Hyg                               | iene                        |                                     |
|-------------|---|---------------|---|--|------------------------------|--|-------------------------------------|--|-----------------------------|-------------------------------------|
|             |   |               | State Registrar   |  | Cei                          | tificate of                              | Death                               |  | og. N2 () () 5              | 42299                               |
| п           | Physici   | an            | Decedent's Name (First, Middle, La  | ist)   |                              |  |                                     | 2. Date of Dear<br>Month                 | Day Year                    |                                     |
|             | /Medic  | al.           | Eugene Milton  4a. Facility Name (If not institution, given   |  |                              | 4b. City, Town, o                        | r Location of De                    | <u>December</u>                          | 4 2005<br>4c. County of Dea | 9:20 P <sup>M</sup>                 |
| Е           | Examin  | er            | 1909 Belle Hay  |  |                              |  | Hvattsv:                            |  |                             | e George's                          |
|             | Funeral   |               | 5. Social Security Number 6. 5  | Sex 7. Age (In yrs. la                               | ast birthday)                | If Under 1 Year<br>Months Days           |                                     | s. 8. Date of Birth                      |                             | rthplace (State or Foreign          |
| Е           | Director  |               | 3.0 .0 3.00   | 1\\ M 2□F 68   | Yrs.                         | Worming Days                             | Tiodis iti                          | Mar. 16                                  |                             | ash., DC                            |
|             | and and   |               | Usual Residence of Decedent  10a. State 10b. County   | 10c. City  | , Town or Lo                 | cation                                   |                                     |  |                             | 10d. Inside City Limits             |
|             | Many<br>Iso   | tor           | Maryland Prince   | George's   |                              | Hyat                                     | tsville                             |  |                             | 1 X Yes 2 □ No                      |
|             | th the<br>or 28a<br>e notifi  | Director      | 10e. Street and Number  |  |                              | 10f. Zip Code                            | 2070                                |  | 0g. Citizen of What C       |                                     |
|             | within 72 hours after death with the Maryland<br>jiene.<br>Ithan "neturel", or Items 23e or 28e-f show<br>Itte Madical Examiner must be notified at | raiD          | 1909 Belle Ha   |  |                              |  | 2078                                |  |                             | d States                            |
|             | er de:  | Funerai       | 11. Marital Status  1 Never Married 2 Married   | 12. Was Decedent Ever in U.S<br>Armed Forces?        | S. 13. \                     | Was Decedent of H<br>f Yes, specify Cuba | lispanic Origin?<br>an, Mexican, Pu | (Specify Yes or No-<br>erto Rican, etc.) | 14. Race - Am<br>Black, Wh  | erican Indian,<br><b>Pret</b> ican  |
| 35          | irs aft   | by F          | 3 Widowed 4 Divorced  | 1 A Yes 2 □ No<br>If Yes, Give<br>Year or Dates:     |                              | 1□Yes 2∏ No                              | Specify:                            |  | Specify: A                  | merican                             |
| 215-0036    | 2 hou   | ted           | 15. Decedent's E<br>(Specify only highest gr  | ducation   | 16a. Deced                   | dent's Usual Occup                       | ation                               | ndking                                   | 16b. Kind of Business       | s/Industry                          |
| 21          | ithin 7   | Completed     | Elementary/Secondary (0-12)   | College (1-4or 5+)                                   | life. I                      | ndarman F                                | 1)                                  |  | Gover                       | nment                               |
| N           | e filed w<br>Il Hygier<br>other th  |               | 17. Father's Name (First, Middle, Lasi  |  | No.                          | darman r                                 |                                     | ame (First, Middle, I                    |                             | Imeric                              |
| anc         | Q 5 0 9   | o Be          |   |  |                              |  | 10. 1001101314                      |  | ra Virgini                  | a Harley                            |
| Maryland    | d 2 should be<br>th and Menta<br>7 Is marked<br>traumatic ev  | 은             | Leo Marque  |  | 19b. Mailir                  | ng Address (Street                       | and Number or                       |  | ; City or Town, State,      |                                     |
|             | nd 2<br>lith a<br>27 Is<br>r tra  |               | Carietta L. Ga  |  |                              |  |                                     | 4, Portsmo                               | outh, VA                    | 23704                               |
| Baltimore,  | ges 1 and<br>t of Healt<br>If item 2:<br>or other t   |               | 20a. Method of Disposition 1  | Bemoval from State                                   | ace of Dispo<br>metery, cren | sition (Name of<br>natory or other p     | em. ¦                               | Date                                     | 20c. Location - City o      | r Town, State                       |
| Ĕ           | permit. Pages<br>Department of<br>Important: If it<br>any injury or o   |               | 4 □Donation 5 □ Other (Speci  | (fy) Ar  |                              |  |                                     | /27/2005                                 | Arlingto                    | n, VA                               |
| Ball        | Sermit<br>Depart<br>mpor<br>mpor<br>any in  |               | 21. Signature of Filheral Service Lice  | hsee   | 22                           | 2. Name and Addre                        |                                     |  | Funeral Ho                  |                                     |
|             | *   |               | 23a. Part1. Enter the disease, or con   | polications that caused the death                    | . Do not ent                 |  |                                     |  | . Wash., D                  | Approximate                         |
|             | Cincal State  |               | shock, for heart failure. List only<br>Immediate Cause (Final   | one cause on each line.                              |                              |  |                                     |  |                             | Interval Between<br>Onset and Death |
|             | mysician<br>/Medical  |               | disease or condition resulting in death)  | Arteriosc1   |                              | пурегсе                                  | nsive ne                            | eart Disea                               | ise                         |                                     |
|             | Examiner  |               | Sequentially list conditions  | b  |                              |  |                                     |  |                             |                                     |
|             | sit ad  | iner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ                              | ence of):                    |  |                                     |  |                             |                                     |
|             | and<br>and<br>Il-tran   | Examine       | that initiated events resulting in death) Last  | c<br>Due to (or as a consequ                         | ence of):                    |  |                                     |  |                             |                                     |
| 760         | death certificate be executed<br>e attending physician and<br>id for use as the burial-transit  | icai E        |   | d  |                              |  |                                     |  |                             |                                     |
| 89          | ifficate<br>g phy<br>as the   |               |   | U  |                              |  |                                     |  |                             |                                     |
| ŏ           | eath certific<br>attending p  | Physician/Med | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregnar 1□Live birth 2□Fetal |                              | Ectopic pregnancy                        | ,                                   |  | 23d. Date of de             |                                     |
| O. B        | it the dea<br>by the att  | sicia         | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4□Pregnant at time of de<br>9□Unknown                |                              | Other (specify)                          |                                     |  | Month                       | Day Year                            |
| ٦.          | The law requires that the<br>ite has been signed by th<br>page 2 should be detache  |               | Part II. Other significant conditions   | contributing to death but not resu                   | Iting in the u               | nderlying cause giv                      | en in Part I.                       | 23e. Did toi                             | pacco use contribute t      | to the cause of death?              |
| Records,    | uires that<br>signed b  | d by          |   |  |                              | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |                                     |  | s 2□No 3□P                  | _                                   |
| COL         | w require<br>been signature<br>should b   | Completed     |   |  |                              |  |                                     | 24a. Was a                               | n 24b. Were a               | utopsy findings available           |
| H.          | : The law<br>cate has b<br>page 2 s   | omp           |   |  | -                            |  |                                     | autops<br>perforr                        | y prior to                  | completion of cause of              |
|             |   | Be C          | 25. Was case referred to medical  |  |                              |  | 26. Place of D                      | eath (Check only on                      |                             | 5 2 10                              |
| >           | Physic<br>this ce<br>al direc   | ToE           | examiner?<br>1. X Yes 2 □ No  |  | ER/Outpatien                 | it 3□ DOA Oth                            | er: 4 🗆 Nursing                     | Home 5 Reside                            | ence 6 Other (Spe           | ecify)                              |
| n<br>O      | ding Ph<br>h.<br>After th<br>funeral  | ion:          | 27. Manner of Death  1 Natural 5 Pending  | (Month, Day Year)                                    | 28b. Time of<br>Injury       | Wor                                      |                                     | 28d. Describe ho                         | ow injury occurred          |                                     |
| Division of | or Attanding Physicien: ifter death. Director: After this certifics in by the funeral director,   | ertification: | 2 Accident investigation 3 Suicide 6 Could not in   | be 280 Blood of Injury - At hor                      | me, farm, str                |  | Yes 2 □ No                          | 28f. Location (St                        | reet and Number or F        | lural Route Number.                 |
| <u>≥</u>    |   | erti          | 4 Homicide determined   | building, etc. (Specify,                             |                              | 001, 1001017, 011100                     |                                     | City or Town                             |                             | ,                                   |
|             | Hospitel or Attsru<br>24 hours after deatl<br>Funerel Director:<br>tely filled in by the  | sai C         |   | hysicien: To the best of my know                     |                              |  |                                     |  |                             |                                     |
|             |   | ledical       | one)  | and manner stated.                                   |                              |  |                                     |  |                             |                                     |
|             | To the within To the comple   | Σ             | 29b. Signature and title of certifier   | 10=1   | <b>3</b> 7                   | 29c. Licens                              |                                     |  | 9d. Date signed (Mon        |                                     |
| Λ           | (in)  |               | 30. Name and address of person who  | competed cause of death /lion                        | 23a) (Tuno                   | Print)                                   | Salve                               | dor Sylve                                | occ cm                      | ber 14 2005                         |
| 1           | (10)  |               | 300/ Hame and address of person who   | cital Dri  | re                           | Chr                                      | 14/4                                | Mary                                     | Inva                        |                                     |
| jk.         | Sta   |               | 31. Date filed (Month, Day, Year)   | 2. Registrar's Signat                                | ure                          | 705                                      | 11                                  |  |                             |                                     |
|             | Registr   | ar            | DEC 1 6 200   | 3 Blow A   | Region                       |  |                                     |  |                             |                                     |

|   |                | 1 - For<br>State<br>Registrar   | State of Maryland  | -                             | artment of H<br>rtificate of L   |  |                                     | iene                           | )5                            | +2300  |
|---|----------------|---|--|-------------------------------|--|--|-------------------------------------|--------------------------------|-------------------------------|--|
| Physici   | an             | 1. Decedent's Name (First, Middle, Las  |  |                               |  |  | 2. Date of Deat<br>Month            | h<br>Day                       | Year                          | 3. Time of Death   |
| /Medic  |                | WILLIE  | GREEN  |                               |  |  | Dec. 1                              | 7                              | 5<br>ty of Death              | 2:50 A M   |
| Examin  | er             | 4a. Facility Name (If not institution, give   |  | 137                           | 4b. City, Town, or   |  |                                     | Prince                         |                               | rgo t a  |
| Funeral   |                | ST. THOMAS MORE N 5. Social Security Number 6. Se   |  |                               | Hyattsv:<br>If Under 1 Year  | If Under 24 Hrs.                           | 8. Date of Birth                    |                                |                               | lace (State or Foreign try)  |
| Director  |                | 578-38-9874   | <b>X</b> M 2□F 79  | Yrs.                          | Months Days  | Hours Min.                                 | (Month, Day, Sept.12                |                                |                               | er.S.C.  |
| pu 🖈  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c City   | /, Town or Lo                 | ocation  |  |                                     |                                |                               | 0d. Inside City Limits   |
| shove   | 5              |   |  |                               | 302(1011   |  |                                     |                                |                               | 1 <b>∑</b> Yes 2 □ No  |
| the N   | Director       | Maryland Prince Ge 10e. Street and Number   | eorge's La   | urel                          | 10f. Zip Code  |  | 1                                   | 0g. Citizen of                 | What Coun                     | try?   |
| 3a or   |                | 275 Red Clay Road   |  |                               | 20   | 724  |                                     |                                | U.S.A.                        |  |
| death<br>ms 2   | Funerai        | 11, Marital Status  | 12. Was Decedent Ever in U.<br>Armed Forces?   | S. 13.                        | Was Decedent of Hi   |  | ecify Yes or No-                    | 14. Ra                         | ce - Americ                   | an Indian,   |
| after<br>or Ite   | F.             | 1 ☐ Never Married 2 ☐ Married   | 1 🔀 Yes 2 🗆 No<br>If Yes, Give   |                               | 1 ☐ Yes 2 X No   | Specify:                                   | 1 110211, 0101,                     | Spec                           | ifv:                          |  |
| 72 hours after death with the Maryland<br>natural', or Items 23a or 28e-f show<br>Ursal Examiliar must be motified at   | d by           | 3 AWidowed 4 □ Divorced   | Year or Dates: WWI   |                               | dent's Usual Occupa  | Man  |                                     | 16b. Kind of I                 | Bla                           |  |
| n 72  | Completed      | 15. Decedent's Ed<br>(Specify only highest gra-   | de completed)  | /Give                         | kind of work done a<br>DO NOT use retired,   | luring most of work                        | ing                                 | 166. Killa oli i               | Dusinessy inc                 | usity  |
| iene.   | шо             | Elementary/Secondary (0-12)  9th  | College (1-4or 5+)   | ]                             | Laborer  |  | J                                   | Privat                         | e Indu                        | ıst <del>ry</del>  |
| other<br>Jent,  | a              | 17. Father's Name (First, Middle, Last)   |  |                               |  | 18. Mother's Name                          | e (First, Middle, I                 | Maiden Suma                    | me)                           |  |
| uld be<br>Aenta<br>rrked<br>ritic e   | To B           | Charlie Green, S  | r.   |                               |  | Char1cy                                    | McKie                               |                                |                               |  |
| 12 should be filed within 7:<br>12 should be filed within 7:<br>1 and Mental Hygiene.<br>7 is marked other than in reaumatic event, the Maul  |                | 19a. Informant's Name/Relationship (7   |  | 19b. Maili                    | ng Address (Street a   | and Number or Run                          | al Route Number                     | City or Town                   | n, State, Zip                 | Code)  |
| 1 and<br>Health<br>em 27  |                | Charmaine Green Ch  | DOL D  | lane of Dies.                 | ed Clay Reposition (Name of  |  |                                     | yland<br>20c. Location         |                               | un State   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show appringing or other traumatic event, the Madical Examinat must be notified at once. |                | 20a. Method of Disposition 1 Burial 2 Cremation 3 2   | Removal from State   | emetery, cre                  | matory or otherplace   | rch  |                                     |                                |                               |  |
| t. Pa<br>dmen<br>rtant:<br>njury  |                | <ul> <li>4 □Donation 5 □Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>           |  | salem                         | Branch Bar<br>2. Name and Addres   | pt. Dec.                                   | 16,2005                             | Salle                          | y, Sou                        | th Carolin   |
| permit. Departimport any inj  |                | 1///  |  | F.                            | raziorie 1   | Funeral F                                  | lome, Ind                           | C.                             |                               |  |
|   |                | 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only                                  | plication that caused the death  | n. Do not en                  | 89 Rhode<br>ter the mode of dying  | Island Av<br>g, such as cardiac            | or respiratory arr                  | est, Wa                        | sh.,DC                        | Approximate Interval Between   |
| Physician   |                | Immediate Cause (Final  | M VO CO C  | ali.                          | ,0   | Taxch                                      | ias.                                |                                |                               | Onset and Death  |
| /Medical  |                | disease or condition resulting in death)  | Due to (or as a consequence  | uence of):                    | a an   | 140CII                                     |                                     |                                | - / /                         | Cirrei S.  |
| Examiner  |                | Sequentially list conditions.   | b  |                               | V  |  |                                     |                                |                               |  |
| p is  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ  | uence of):                    |  |  |                                     |                                |                               |  |
| ecute<br>and<br>I-trans   | Examiner       | that initiated events resulting in death) Last  | C Due to (or as a consequence  | uence of):                    |  |  |                                     |                                |                               |  |
| icate be executed physicien and sthe burial-transit   | a<br>E         |   |  |                               |  |  |                                     |                                |                               |  |
| ficate<br>physics the   | edicai         | 12.75   |  |                               |  |  |                                     |                                |                               |  |
| w requires that the death certifue signed by the attending should be detached for use as  | N/             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregna   |                               | ⊒Ectopic pregnancy   |  |                                     |                                | ate of delive                 |  |
| death   | Physician/M    | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4 Pregnant at time of de   |                               | Other (specify)  |  |                                     | N                              | lonth                         | Day Year   |
| by th   | hys            | 9 ☐ Unknown   |  |                               |  | -0.0                                       |                                     |                                |                               | and the state of t |
| es the  | þ              | Part II. Other significant conditions c   | ontributing to death but not resi  | ulting in the u               | Inderlying cause give  | en in Part I.                              |                                     | es 2 □ No                      |                               | e cause of death? ably 4 🖳 Unknown   |
| requi   | Completed      | Cosoria cg  | 040190   | 10                            |  | ·  |                                     |                                |                               |  |
| e law<br>has b  | npie.          | regressen   | fien   |                               |  |  | 24a. Was a autops perform           | V                              | prior to cor<br>death?        | psy findings available<br>npletion of cause of   |
| r: Th   |                | Dialei  | es:  |                               |  |  | 1 ☐ Yes                             | 2 <b>X</b> No                  | 1 🗆 Yes                       | 2□ No  |
| siciar<br>certif<br>irecto  | o Be           | 25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{Yes} \)                           | Hospital: 1 ☐ Inpatient 2 ☐  | ER/Outpatie                   | nt 3□ DOA Othe   | 26. Place of Deat                          | me 5 ☐ Reside                       |                                | ther (Specifi                 | /)   |
| Phys<br>arthis  | 7: To          | 27. Manner of Death   | 28a. Date of Injury  | 28b. Time o                   |  |  | 28d. Describe ho                    |                                |                               | ,  |
| ath.<br>T. Afte   | ation          | t Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Month, Day Year)  | Injury                        |  | Yes 2 □No                                  |                                     |                                |                               |  |
| Atte  | Certification; | 3 Suicide 6 Could not be determined   |  |                               | reet, factory, office  |  | 28f. Location (Si<br>City or Town   |                                | nber or Rura                  | I Route Number,  |
| talog<br>rs after<br>ed in  | Cer            |   | 3, 11, 12, 12, 12, 12, 12, 12, 12, 12, 12  |                               |  |  |                                     |                                |                               |  |
| To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be delached for use as  | edicai         | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exam   | ysicien: To the best of my kno<br>niner: On the basis of examina<br>and manner stated. | wledge, dea<br>tion and/or in | th occurred at the time the time of time of the time of the time of the time of the time of time of time of time of the time of ti | ne, date and place,<br>pinion, death occur | and due to the cared at the time, d | ause(s) and n<br>ate and place | nanner as st<br>e, and due to | ated.<br>the cause(s)  |
| To th<br>withir<br>To th<br>comp  | Me             | 29b. Signature and title of certifier   | 0-1:1  | )                             | 29c. License   | e number                                   |                                     | 9d. Date sign                  | _                             | Day, Year)   |
| 5   |                | Kalua   | uf luc   | 1. 1                          | 7 11   | 601.                                       |                                     | 2.10                           | 1.03.                         |  |
| BI  |                | 30. Name and address of person who  |  |                               |  |  |                                     | _                              |                               |  |
| J   |                | Raman R. Tuli,  | MD 4203 (  |                               | bury Raod  | Hyattsv                                    | ville, M                            | arylan                         | d 207                         | 82   |
| St<br>Regist  | ate<br>rar     | DEC 1 5 2005  | de to  | de                            |  |  |                                     |                                |                               |  |
|   |                |   |  | - <del></del>                 |  |  |                                     |                                |                               |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** H. IRENE GREENWOOD DECEMBER 21 2005 10:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLIAM HILL MANOR EASTON TALBOT 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
JULY 6, 1917 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 耳F Months Days Hours 217-30-7685 88 WEST VIRGINIA Yrs. Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "neturel", or items 23s or 28e-1 show other traumatic event, the Modical Examinar must be notified at 1X Yes 2 □ No MD Funeral Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pagas 1 and 2 should be filed within nent of Health and Mental Hygiene. snt: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 9 BOOKKEEPER PROPERTY MANAGEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be OLIVER CROMWELL ISNER LUNA BYRD WILMOTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH A. LAPPEN/DAUGHTER 29367 PRICE ST., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department of Importent: If any injury of once. WOODLAWN MEMORIAL PARK 12/27/2005 EASTON, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA Ostrow/i 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

21601

200 S. HARRISON ST EASTON MD 21601

shock, or heart failure. List only one cause on each line. Voscoph Approximate Interval Between Onset and Death Immediate Cause (Final 4 cute Physician 3 his disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): attending physicien Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Ves 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 XNo Certification: To 4 Stursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 [Matural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending М 1 Tes 2 No 2 Accident investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title 29d, Date signed (Month, Dav. Year) 2108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Registra Signature State Registrar

Donald Lee Green Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#2a,27,perMF,0851,1-4-06 III State of Maryland / Department of Health and Mental Hygiege 05-8364 AKG Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 11, Donald 2005 Lee Green 12:02 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Calvert Prince Inder 1 Year Frederick 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)

April 26 1947

8. Birthplace (State or Foreig Country)

Washington DC **Funeral**  Birthplace (State or Foreign Country) Min. Davs Hours 1**□**M 2□F Months 219-48-7311 Director 58 Yrs. Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 23a or 28a-1 ehow 10d. Inside City Limits the Medical Examiner must be notified at Maryland Completed by Funeral Director Calvert Prince Frederick 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 423 Park Terrace # 20678 United States filed within 72 hours after death items! 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. ☐Yes 2**∑** No 1 Yes, Give 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: white 3 Widowed 4 Divorced "netural", Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ personel recruiter <u>pipe fitters union</u> other of permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg Important: if tiers 27 is marked other eny injury or other traumering page. event. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Eugene W. Green Louise Earp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia J. Green- wife 423 Park Terrace # 4 Prince Frederick MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Chesapeake Highlands Manorial Cardens Port Republic Maryland 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Hone GKause 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician by Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? 1DXYes 2 □ No funeral director 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) TXTXYes 2 □ No Certification; To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending i efter death.
ii Director: Af М investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours eff To the Funerel Di 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

a se of death (Item 23a) (Type, Print)

32. Ferristra Signature

Clasur.

nDera

2005

19

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

December 12, 2005

|                                       |  |                  | 1 - For State Registrar   | State of Maryla  | nd / Depa                               | artment<br>rtificate       | of He                   | ealth a<br>Death    | nd Me             |                               | ene () (        | )5                         | 42304                                 |
|---------------------------------------|--|------------------|---|--|---|----------------------------|-------------------------|---------------------|-------------------|-------------------------------|-----------------|----------------------------|---------------------------------------|
|                                       | Dhysia   | i                | 1. Decedent's Name (First, Middle, Last   | )  |   |                            |                         |                     | 2                 | . Date of Death               |                 |                            | 3. Time of Death                      |
|                                       | Physic<br>/Medi  |                  | Dru J   | ennifer Grang  | ger                                     |                            |                         |                     |                   | Month<br>Decembe:             | r 22            | 2005                       | 6:07 P <sup>M</sup>                   |
|                                       | Examir   |                  | 4a. Facility Name (If not institution, give   | street and number)                                       |   | 4b. City, 1                | Town, or I              | Location of         |                   |                               | 4c. County      |                            | 0.07 1                                |
|                                       |  |                  | Union Hospital  |  |   | E1k                        | tton                    |                     |                   |                               | Cecil           |                            |                                       |
|                                       | Funeral  |                  | 5. Social Security Number 6. Se   | 7. Age (In yrs.  | • | If Under<br>Months         | 1 Year<br>Days          | If Under 2<br>Hours | 4 Hrs. 8.<br>Min. | Date of Birth                 |                 | 9. Birthpi                 | lace (State or Foreign<br>try)        |
|                                       | Director   |                  | Usuel Residence of Decedent   | 1 1  | Yrs.                                    |                            |                         | 7,100,10            | 0                 | Date of Birth (Month, Day, )  | 2004            | Dela                       | ware                                  |
|                                       | land   |                  | 10a. State 10b. County  | 10c. C   | ity, Town or Lo                         | cation                     |                         |                     |                   |                               |                 |                            |                                       |
|                                       | Mary   | ō                | Maryland Cecil  |  |   |                            |                         |                     |                   |                               |                 | 10                         | Od. Inside City Limits 1 ☐ Yes 2 🕅 No |
|                                       | 138 the  | Je C             | Maryland Cecil  10e. Street and Number  |  | ising                                   | oun<br>10f. Zip (          | 0040                    | -                   |                   |                               |                 |                            |                                       |
|                                       | 3e or  | 0                | 368 Chrome Road   |  |   | 219                        |                         |                     |                   | 100                           | J. Citizen of V |                            | ,                                     |
|                                       | be liled within 72 hours after daath with the Maryland itel Hygiene. A charten a dother then "naturel", or iteme 23e or 28e-f ehow event, the Madical Enatural rational Le notilled at   | Funeral Director | 11. Marital Status  | 12. Was Decedent Ever in L                               | I.S. 13 V                               |                            |                         | nanic Origi         | in? (Specif       | y Vos es No                   | Unite           |                            |                                       |
| 9                                     | or Ite   |                  | 1 Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☐ XNo                         |   |                            |                         | , Mexican,          | Puerto Ric        | y Yes or No-<br>an, etc.)     | Blac            | e - America<br>k, White, e | an Indian.<br>etc.                    |
| 3                                     | ours a   | þ                | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:                           |   | 1 ☐ Yes 2                  | No                      | Specify:            |                   |                               | Specify         | Whi                        | te                                    |
| 9200-51212                            | 72 ho  | Completed        | 15. Decedent's Edu<br>(Specify only highest grad  | cation   | 16a. Deced                              | ient's Usual               | Occupat                 | ion                 |                   | 16                            | 6b. Kind of Bu  |                            |                                       |
| 7                                     |  | npie             | Elementary/Secondary (0-12)   | College (1-4or 5+)                                       | life. L                                 | kind of work<br>DO NOT use | ( done du<br>e retired) | ring most o         | of working        |                               |                 |                            |                                       |
| 7                                     | ygien<br>rerth   | ပ္ပ              | 0   |  | No                                      | t Appl                     | licat                   | ole                 |                   |                               | Not A           | pplic                      | able                                  |
| /land                                 | d oth  | Be               | 17. Father's Name (First, Middle, Last)   |  |   |                            | 1                       | 8. Mother           | s Name (F         | irst, Middle, Ma              |                 |                            |                                       |
| <u>×</u>                              | Meni   | ုင               | Stephen E. Grang  | er   |   |                            | -                       | Diar                | na K.             | Heideg                        | ger             |                            |                                       |
| Маг                                   | 12 should be filed with<br>and Mentel Hygiene<br>7 is marked other the<br>reumatic event, the h  |                  | 19a. Informant's Name/Relationship (Ty  |  |   |                            |                         | d Number            | or Rural R        | oute Number, C                | City or Town,   |                            |                                       |
| 2                                     | end<br>ealth<br>m 27   |                  | Jonathan F. Gran  |  |   |                            |                         |                     | ad, E             | lkton, l                      | Maryla          | nd 21                      | 921                                   |
| saltimore,                            | permit. Pages 1 end 2 should by Department of Health and Mente Important: If Item 27 is marked eny Injury or other treumatic evance.   |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F   | 20b. F   | Place of Disposemetery, crem            | sition (Name               | e of<br>ner place)      | D                   | ecemb             | her 20                        | c. Location -   | City or Tov                | vn, State                             |
|                                       | ment:  |                  | 4 Donation 5 Other (Specify)  |  | ay View                                 |                            |                         |                     | 26, 20            |                               | ay View         | v. Ma                      | rvland                                |
|                                       | Depart<br>Depart<br>Import<br>eny Inj  |                  | 21. Signature of Funeral Service License  | 9  | H2                                      | Name and                   | Address                 |                     |                   | als, P.A                      | , , , ,         | ,, 114                     | r y rand                              |
|                                       | 80 E B B   |                  | Donud S.  | Licks  | 110                                     | J3 W.                      | Stoc                    | kton                | Stree             | et. Elkt                      | con. Ma         | arvla                      | nd 21921                              |
|                                       |  |                  | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or  | cations that caused the deat                             | h. Do not ente                          | er the mode                | of dying,               | such as ca          | ardiac or re      | spiratory arrest              |                 |                            | Approximate                           |
| F                                     | hysician   |                  | Immediate Cause (Final disease or condition   |  | Asphiles                                |                            |                         |                     |                   |                               |                 |                            | Interval Between<br>Onset and Death   |
|                                       | /Medical   |                  | resulting in death)   | Due to (or as a conseq                                   | uence of):                              | u                          |                         |                     |                   |                               |                 |                            |                                       |
|                                       | xaminer  |                  | Sequentially list conditions  |  |   |                            |                         |                     |                   |                               |                 |                            |                                       |
| 1                                     | 2 =  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury   | Due to (or as a conseq                                   | uence of):                              |                            |                         |                     |                   |                               |                 |                            |                                       |
|                                       | ind  | am               | Cause (Disease or injury that initiated events resulting in death) Last   |  |   |                            |                         |                     |                   |                               |                 |                            |                                       |
| Ž                                     | Slen a<br>urial:   |                  | resulting in death) cast  | Due to (or as a conseq                                   | uence of):                              |                            |                         |                     |                   |                               |                 |                            |                                       |
| 0070                                  | physiclen and<br>s the burial-transit  | dical            |   |  |   |                            |                         |                     |                   |                               |                 |                            |                                       |
| 0                                     | ingp   | Mec              | IF FEMALE:  |  |   |                            |                         |                     |                   |                               |                 |                            |                                       |
| The four contract from the destroyer. | ed by the attending I  | Physician/Me     | 23b. Was decedent pregnant in the past 12 months?   | lc. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta |   | Ectopic preg               | ากลกะง                  |                     |                   |                               | 23d. Date       | of delivery                | ,                                     |
|                                       | the a  | Sici             | 1 ☐ Yes 2 🗗 No  | 4☐Pregnant at time of de<br>9☐Unknown                    |   | Other (spec                | ify)                    |                     |                   |                               | Mon             | th D                       | ay Year                               |
|                                       | d by t   | 된                | 9 Unknown   |  |   |                            |                         |                     |                   |                               |                 |                            |                                       |
| <u> </u>                              | been signed to   | Ď                | Part II. Other significant conditions con   | ributing to death but not resi                           | ulting in the un                        | derlying cau               | se given                | in Part I.          |                   | 23e. Did tobac                | co use contril  | oute to the                | cause of death?                       |
| 5                                     | ould sould   | Completed        |   |  |   |                            |                         |                     |                   | 1 Tes                         | 2 No 3          | Probab                     | oly 4 Unknown                         |
| ב כ                                   | hes b  | Pje              |   |  |   |                            |                         |                     |                   | 24a. Was an                   | 24b. W          | ere autops                 | y findings available                  |
|                                       |  | Son              | /   |  |   |                            |                         |                     |                   | autopsy<br>performed          | 1? or           | or to comp<br>ath?         | pletion of cause of                   |
| Physician:                            | is certificate he<br>director, page  | Be (             | 25. Was case referred to medical examiner?  |  |   |                            | 2                       | 6. Place of         | Death (Cr         | 1 Yes 2                       | No              | Yes 2                      | □ No                                  |
| 2 2                                   | this co  | 2                | NXYes 2 □ No H  | ospital: 1 Inpatient 200                                 | <b>E</b> R/Outpatient                   | 3□ DOA                     | Othon                   |                     |                   | 5 Residence                   | a 6 ∏Other      | (Snaciful                  |                                       |
| - 2                                   | . e e  | ë                | 27. Manner of Death 1 ☐Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)                 | 28b. Time of<br>Injury                  | 28c                        | Injury at<br>Work?      |                     | 28d.              | Describe how i                | niury occurre   | Tropp                      | ad in                                 |
| ם פ                                   | tor: A   | at               | 2 Accident investigation  | Found 12/22/05   | Found 4:5                               | EM                         | 1 Tes                   | 2 No                |                   | upsed pe                      | st-a-cr         | 6                          |                                       |
| A                                     | Irect<br>Irect   | Certification:   | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At ho<br>building, etc. (Specify  | me, tarm, strai                         | et, factory, o             | office                  |                     | 28f. I            | Location (Street              | and Number      | or Rural F                 | Route Number.                         |
| ב ב                                   | re d Del   |                  |   | 1  | ome                                     |                            |                         |                     | 1                 | City or Town, Si<br>NG SUN, V | 11 368          | Chron                      | ne Rd.                                |
| 90                                    | Fune<br>ely fil  | ledical          | 29a. Certifier  (Check only  ( | cian: To the best of my know                             | wledge, death                           | occurred at                | the time,               | date and p          | dana and          | 4. 4. 41.                     | e(s) and man    | ner as state               | ed.                                   |
| TOISIVID                              | within 24 hours effer death.  To the Funerel Director: A completely filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled in by the funerel filled filled in by the funerel filled fille |                  | 1//   | ar: On the basis of examinat<br>and manner stated.       | ion and/or inve                         | estigation, in             | my opini                | on, death o         | occurred at       | the time, date                | and place, an   | d due to th                | e cause(s)                            |
| -                                     | To To  | Σ                | 29b. Signature and title of certifier   |  |   | 29c. L                     | icense n                | umber               |                   | 29d.                          | Date signed     | Month. Da                  | y. Year)                              |
|                                       |  |                  | Harreth Srichell  | IND  |   |                            | 00                      | ME                  |                   | Dec                           | cember          | 23.                        | 2005                                  |
|                                       |  |                  | 30. Name and address of person who con  | pleted cause of death (Item                              | 23a) (Type, P                           |                            |                         |                     |                   |                               |                 | -,                         |                                       |
|                                       |  |                  |   | ui, MD   |   | 111 F                      | Penn                    | Stree               | et Ba             | altimore                      | e, Mar          | yland                      | 21201                                 |
|                                       | Stat<br>Registra   | .~               | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signat                                   | ure                                     |                            |                         |                     |                   |                               |                 |                            |                                       |
|                                       |  |                  |   |  |   |                            |                         |                     |                   |                               |                 |                            | 1                                     |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dav Year George Alvin Garrison December 4 2005 /Medical 12:15a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heartland Healthcare Hyattsville Prince Georges If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Director 577-42-0784 72 Yrs. 9, Washington, D.C Aug. 1933 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Engither must be notified at Director 1₺Yes 2☐No D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4832 Illinois Ave. N.W. 20011 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give 1952 Year or Dates: 19 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 N Divorced Black 1956 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. markad other than Elementary/Secondary (0-12) College (1-4or 5+) Postal Worker 1 year Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) as 1 and 2 should be fill of Health and Mental H Be Arthur Garrison Effie Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Garrison Bonner/Sister 405 Thom Hall Dr. Hampton, VA. 23663 othar 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ott once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery | 12-9-2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11/11/41 4217 9th St. N.W. Washington, DC 20011 23a. Pg.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final **Physician** Alzheimers Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown sbeen signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 KUnknown has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? this certificate 1□ Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 X Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident the f Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0058290 12-7-2005 30. Name and address of person who completed cruse of death (Item 23a) (Type, Print) Sureshkumar Muttath 4203 Queensbury Rd. Hyattsville, Md. 20781 31. Date filed (Month, Day, Year) State 1 3 2005 Registrar

|            |  |  | Amend item#23a,pents.G851,1/30/06 IT<br>State of Maryland / I  |  | d Mental Hygiene                                     |   |  |  |  |  |
|------------|--|--|--|--|--|---|--|--|--|--|
|            |  | 1  | For State Registrar  | Certificate of Death   | Reg. No.   | 05 42306                                  |  |  |  |  |
|            | Physicia   | _  | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death November 27                         | , 2005 10:39PM                            |  |  |  |  |
|            | /Medic   | al -   | Vincent Andre Gant  4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of De  |  | nty of Death                              |  |  |  |  |
|            | Examin   |  | Prince George's Hospital Center  | Cheverly   |  | ce George's                               |  |  |  |  |
|            | Funeral  |  | 5. Social Security Number 6. Sex 7. Age (In yrs. last bi   | thday) If Under 1 Year   If Under 24 H<br>Months Days Hours M              | Irs. 8. Date of Birth<br>in. (Month, Day, Year)      | Birthplace (State or Foreign     Country) |  |  |  |  |
|            | Director   |  | 198-60-4433 <sup>1</sup> X <sup>M 2□ F</sup> 42  | Yrs.   | 07/14/63   | Pennsylvania                              |  |  |  |  |
|            | and<br>and   | -  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow   | n or Location  |  | 10d. Inside City Limits                   |  |  |  |  |
|            | Mary   | ğ  | DC We  | shington   |  | 1 X Yes 2 □ No                            |  |  |  |  |
|            | or 28e   | Director   | 10e. Street and Number   | 10f. Zip Code  | 10g. Citizen   | of What Country?                          |  |  |  |  |
|            | 23a (  |  | 5620 Colorado Avenue NW # 1  | 06 20011   | United   | America<br>States of                      |  |  |  |  |
|            | items<br>items   | by Funeral   | 11. Marital Status  1. Was Decedent Ever in U.S. Armed Forces?  1. ▼Never Married 2 Married 1. ▼Never Married 2. ■ Married 1. ■ Marrie  | 13. Was Decedent of Hispanic Origin?<br>If Yes, specify Cuban, Mexican, Pu | erto Rican, etc.)                                    | Hack, White, etc.                         |  |  |  |  |
| 36         | in 72 hours affer death with the Maryland<br>"naturel", or items 23a or 28e-f ehow<br>egical Exartinat must be notified at | by   | 1 Never Married 2 Married 1 Married  | 1 ☐ Yes 2 X No Specify:  | Spe  | cify: Black                               |  |  |  |  |
| 21215-0036 | 72 hor   | Completed  | 15. Decedent's Education (Specify only highest grade completed)  | Decedent's Usual Occupation<br>(Give kind of work done during most of      | working 16b. Kind of                                 | Business/Industry                         |  |  |  |  |
| 121        | c *_ @   | m<br>M   | Elementary/Secondary (0-12) College (1-4or 5+)   | life. DO NOT use retired)  | Private  |   |  |  |  |  |
|            | filed v<br>Hygie<br>ther t   | မ Co   | 12 2   | Plummer 18. Mother's I   | Name (First, Middle, Maiden Sum                      |   |  |  |  |  |
| au         | should be filed within to Mental Hygiene. marked other then matic event, Italy   | To B   | Floyd L. Gant  | Lo   | uise Corbett   |   |  |  |  |  |
| 듑          | ~ = = =  |  | 19a. Informant's Name/Relationship (Type, Print)   | o. Mailing Address (Street and Number or                                   | Rural Route Number, City or Tox                      | wn, State, Zip Code) 20011                |  |  |  |  |
| Σ.         | and 2<br>ealth a<br>m 27 ls  |  | THICH IN THE STATE OF THE PARTY | 6620 Colorado Av   |  | Vashington, DC                            |  |  |  |  |
| Baltimore, | ges 1  |  | 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 20b. Place cemeter   | rdale Park   | 12/8/05 River  | dale. Marvland                            |  |  |  |  |
| Ē          | it. Pa<br>utmen<br>utent:<br>njury   |  | 4 □ Donation 5 □ Other (Specify) Rive  21. Signature of Funeral Service Licenses   | rdale Park 22. Name and Address of Facility                                |  | 1   |  |  |  |  |
| Ва         | permit. Pages 1 and 2<br>Department of Health a<br>Importent: If Item 27 is<br>eny Injury or other tre                     | 100  | Phillip Bell to  | Georgia Avenue   |  | 1 Home - 4804                             |  |  |  |  |
|            |  |  | 23a. Part1. Enter the disease or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Complications  | not enter the mode of dying, such as care                                  | diac or respiratory arrest,                          | proximate  I Between                      |  |  |  |  |
|            | Physician-   | 0 4  | Immediate Cause (Final disease or condition  | ons of longite   |  | and Death                                 |  |  |  |  |
|            | /Medical<br>Examiner   |  | resulting in death)  Due to (or as a consequence   | of):   |  | 1025000 Table 1                           |  |  |  |  |
|            | 7  | ايرا   | Sequentially list conditions, b. Due to for as a consequent.   | >f);   |  |   |  |  |  |  |
|            | uted<br>3<br>Insit   | Examiner   | in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |  |  |   |  |  |  |  |
| o,         | exected and and rial-tra   | Exa  | resulting in death) Last  C.  Due to (or as a consequence  | of):   |  |   |  |  |  |  |
| 8760,      | thet the death certificate be executed<br>ed by the attending physicien and<br>detached for use as the burial-transit      | Icai   | d  |  |  |   |  |  |  |  |
| 9 x        | entific<br>ding p  | /Med   | IF FEMALE: 23c. If yes, outcome of pregnancy   |  | 234  | Date of delivery                          |  |  |  |  |
| Вох        | death c<br>e atten   | by Physician/Med   | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal deal   | h 3 Ectopic pregnancy 5 Other (specify)                                    | 200.   | Month Day Year                            |  |  |  |  |
| O.         | thet the d<br>ed by the<br>detached  | hysi   | 1 Yes 2 No 9 Unknown   |  |  | - Avery                                   |  |  |  |  |
| S,         | S 5 0  | by P   | Part II. Other significant conditions contributing to death but not resulting  | in the underlying cause given in Part I.                                   | 2.4  | contribute to the cause of death?         |  |  |  |  |
| Records,   | w requires<br>been sign<br>should be   |  |  |  | 1 ☐ Yes 2 N  |   |  |  |  |  |
| ec         | s b  | 24a. Was an autopsy findings prior to completion of current care.  24b. Were autopsy findings prior to completion of current care.  24b. Were autopsy findings prior to completion of current care.  24c. Was an autopsy findings prior to completion of current care. |  |  |  |   |  |  |  |  |
| al H       | The ete  |  |  |  | 1 Yes 2□No   | 1 Pres 2 □ No                             |  |  |  |  |
| Vital      |  | o Be   | 25. Was case referred to medical examiner?  15€ Yes 2 □ No Hospital: 1 12€ Inpatient 2 □ ER/0  | Othors   | Death (Check only one)  ng Home 5  Residence 6       | Other (Specify)                           |  |  |  |  |
| ō          |  | n: To  | 27. Manner of Death 28a. Date of Injury 28b  | Time of Injury at Work?  | 28d. Describe how injury oc                          |   |  |  |  |  |
| io         | ttending fideath.  | atio   | 2 Accident investigation ///2005 D   | 220 M 1 Yes 2 No   | UMADO  | SN  |  |  |  |  |
| Division   | or Att   | Certification:   | 3 Suicide 4 Homicide  3 Suicide 4 Homicide  4 See Place of Injury - At home, building, etc. (Specify)  | farm, street, factory, office  | 28f. Location (Street and No<br>City or Town, State) | umber or Rural Route Number,              |  |  |  |  |
|            | hours a<br>unerel C  | 2  | 29a. Certifier 1 Certifying Physician: To the best of my knowled   | ge, death occurred at the time, date and p                                 | alace, and due to the cause(s) and                   |   |  |  |  |  |
|            | To the Hoepitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the                 | edical   | (Check only 2 XMedical Examiner: On the basis of examination and manner stated.  | ind/or investigation, in my opinion, death o                               | occurred at the time, date and pla                   | ce, and due to the cause(s)               |  |  |  |  |
|            | To th<br>within<br>To th<br>comp   | ₩  | 29b. Signature and title of certifier  | 29c. License number  |  | gned (Month, Day, Year)                   |  |  |  |  |
|            |  |  | (Korkeau)  | O.C.M.E.   | Novem  | ber 29, 2005                              |  |  |  |  |
| R          |  |  | 30. Name and address of person who completed cause of death (Item 23a  | (Type Print)<br>111 Penn Street, B   | altimore, Maryla                                     | and 21201                                 |  |  |  |  |
|            | St<br>Regist   | ate<br>trar  | 31. Date filed (Month, Day, Year) DEC 1 3 2005   | Sports   |  |   |  |  |  |  |

|                     | -4-110   |                     | 1 - For<br>State<br>Registrar   |   | Marylar             |                                 |                                    |                      | ealth a<br>Death                     |                 |                                 | Reg. No                  | 2110                                 | 5         | 42  |                |
|---------------------|--|---------------------|---|---|---------------------|---------------------------------|------------------------------------|----------------------|--------------------------------------|-----------------|---------------------------------|--------------------------|--------------------------------------|-----------|---|----------------|
| 14                  | Physici  | an                  | Decedent's Name (First, Middle     OARDETE  |   |                     |                                 |                                    |                      |                                      |                 | 2. Date of Dea                  | Day                      |                                      | ar        | 3. Time                                       |                |
|                     | /Medic   | al                  | CARRIE  4a. Facility Name (If not institution   | GRIFFITH  | ar)                 |                                 | 4h City                            | Town or              | Location of                          |                 | Decembe                         |                          | 2005 County of D                     | Death     | 17:2  | 0 P M          |
|                     | Examin   | er                  | Prince George   |   |                     | al                              |                                    | ever1                |                                      | or Double       |                                 |                          | rince                                |           | rge   |                |
|                     | Funeral  |                     | Social Security Number  | 6. Sex 7.   |                     | last birthday)                  |                                    | r 1 Year             | If Under<br>Hours                    | 24 Hrs.<br>Min. | 8. Date of Birt<br>(Month, Da   | w Vaarl                  |                                      | Birthpla  | ace (State                                    | or Foreign     |
|                     | Director   |                     | 579-44-2807   | 1 ☐ M 2 🕅 F   | 90                  | Yrs.                            | MOTITIS                            | Days                 | Tiodio                               |                 | Jan. 12                         | 2, 1                     | 915 Sc                               | outh      | ('Car   | olina          |
|                     | and  | 6                   | Usual Residence of Decedent  10a, State 10b. County   |   | 10c. Ci             | ty, Town or Lo                  | ocation                            |                      |                                      |                 |                                 |                          |                                      | 10        | d. Inside (                                   | City Limits    |
|                     | Maryl<br>-f sho  | tor                 | Maryland Prince   | George  | Сар                 | itol H                          | eigh                               | ts                   |                                      |                 |                                 |                          |                                      |           | XXYe  | s 2 No         |
|                     | r 28a  | irec                | 10e. Street and Number  |   |                     |                                 | <del></del>                        | p Code               |                                      |                 |                                 | -                        | izen of Wha                          |           |   |                |
|                     | th wit   | ai D                | 1207 Addison Ro   | ad Apt. #   | 302                 |                                 |                                    | 20743                |                                      |                 |                                 |                          | ted St                               |           |   |                |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal mutilian notified at Once. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 → Marri 3 □ Widowed 4 □ Divorced   | If YAS GIVA   | s?<br>• No          | 1                               | Was Dece<br>If Yes, spe<br>1 ☐ Yes |                      | spanic Ori<br>n, Mexicar<br>Specify: |                 | ecify Yes or No<br>Rican, etc.) |                          | 14. Race - A<br>Black, V<br>Specify: | Vhite, e  | tc.   |                |
| Ö                   | 2 hou  | ted                 | 15. Deceden   | it's Education<br>st grade completed)                       |                     | 16a. Dece                       | dent's Usi                         | al Occupa            | ation                                | t of work       | ina                             | 16b. K                   | ind of Busin                         | ess/Indi  | ustry   |                |
| 215                 | ithin 7<br>9e.<br>Man "r   | Completed           | Elementary/Secondary (0-12)   | College (1-4  | or 5+)              | 1                               |                                    |                      | luring mos<br>)                      | . 0, 40,        | 9                               | D                        | d                                    |           |   |                |
| 2                   | led w<br>lygier<br>her th  | Cor                 | 10th 17. Father's Name (First, Middle,  | Lasti   |                     | Domes                           | tic                                | worke                |                                      | are Name        | e (First, Middle,               |                          | ivate                                |           |   |                |
| anc                 | ntal H   | Be                  | Butler Simpki   |   |                     |                                 |                                    |                      |                                      |                 | aindrop                         | Walder.                  | comame                               |           |   |                |
| Maryland 21215-0036 | should<br>nd Me<br>mark<br>mark  | 2                   | 19a. Informant's Name/Relations   |   |                     | 19b. Maili                      | ng Addres                          | s (Street a          | and Numbe                            | er or Rura      | al Route Numbe                  | er, City o               | or Town, Sta                         | te, Zip ( | Code)   |                |
| Ž                   | alth a   |                     | Lawrence E. Gr  | iffith/ Hu  |                     |                                 | and the second second              |                      |                                      | pt. 3           | 302 Cap                         | itol                     | Heigl                                | nts,      | Md.   | 20747          |
| ore                 | of He  |                     | 20a. Method of Disposition  1    Burial 2 □ Cremation   | 3 □Removal from St.   | 20b. I              | Place of Dispo<br>cemetery, cre | osition (Na<br>matory or           | ime of<br>other plac | 9)                                   | (               | Date                            | 20c. Lo                  | ocation - City                       | y or Tov  | vn, State                                     |                |
| Ĕ                   | Pag<br>Iment<br>tant:  <br>jury o  |                     | 4 Donation 5 Other (S   | Specify)  | Res                 | urrect                          |                                    |                      |                                      |                 | -                               |                          | nton,                                |           | ylan  | d              |
| Baltimore,          | permit<br>Depart<br>Import<br>any in   |                     | 21. Signature of Funeral Service  | Mas   |                     | 55                              | 38 M                               | arlbo                | oro P                                | ike             | uneral<br>Forestv               | ille                     | es, P.                               | 207       |   |                |
| A.                  | Physician  |                     | 23a. Part . Inter the disease, or<br>shock or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)                    | a. Card   | iogeni              | c Shoc                          |                                    | ae or ayını          | g, such as                           | cardiac         | or respiratory a                | rrest,                   |                                      |           | Approxima<br>Interval Be<br>Onset and<br>72hr | tween<br>Death |
|                     | /Medical<br>Examiner   |                     | resulting in death)   |   | as a consec         |                                 | Tnf                                | oroti                | on                                   |                 |                                 |                          |                                      |           | 72hr  | c              |
|                     | . 4. 3   | er                  | Saquentially list conditions, if any, leading to immediate  |   | as a consec         | ardial                          | LILL                               | arcti                | .011                                 |                 |                                 |                          |                                      |           | / 2111  | <u> </u>       |
|                     | ate be executed hysicien and the burial-transit  | Examiner            | Saguantially list or difficults, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or   | as a consec         | quence of);                     |                                    |                      |                                      |                 |                                 |                          |                                      | -         |   |                |
| 68760,              | icate be<br>physicie<br>s the bur  | Ical                |   | d   |                     |                                 |                                    |                      |                                      |                 |                                 |                          |                                      |           |   |                |
| Box (               | death certific<br>e attending pl<br>id for use as t  | an/Me               | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outco  | me of pregn         |                                 | Tectopic i                         | oregnancy            |                                      |                 |                                 | 10.                      | 23d. Date of                         |           | ,   |                |
| o.                  | the deat<br>y the att  | Physician/Med       | in the past 12 months?<br>1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   |   | nt at time of o     |                                 | Other (s                           |                      |                                      |                 |                                 |                          | Month                                |           | Day   | Year           |
| σ                   | ires that the de<br>signed by the a<br>1 be detached f   | þ                   | Part II. Other significant conditi  | ons contributing to dea                                     | th but not re       | sulting in the u                | ınderlying                         | cause give           | en in Part I                         |                 |                                 |                          | use contribu<br>⊠No 3[               |           |   |                |
| Records             | law requires<br>as been sign<br>2 should be  | Completed           |   |   |                     |                                 |                                    |                      |                                      |                 | 24a. Was                        |                          |                                      |           |   | s available    |
| Re                  | 0 - 0  | ошо                 |   |   |                     |                                 |                                    |                      |                                      |                 | autor<br>perfo                  | osy<br>ormed?            | prior                                | to com    | pletion of                                    | cause of       |
| Vital               | ician: Th<br>certificate<br>rector, pag  | 0                   | 25. Was case referred to medical  | at .  |                     |                                 |                                    |                      | 26. Place                            | of Deat         | 1 ☐ Yes<br>h (Check only o      | 2 <sup>1</sup> No<br>ne) | ) 10                                 | 105 4     | Z L INO                                       |                |
| <u></u>             | Physician:<br>r this certificantal director,   | To B                | examiner?<br>1 ☐ Yes  乙☑ No   | Hospital: 1 🗐   | patient 2           | ]ER/Outpatie                    | nt 3 🗆 🖸                           | Oth                  | er: 4□ Nu                            | ırsing Ho       | me 5 Resi                       | dence                    | 6 □Other (                           | Specify)  | )   |                |
| n of                | ding Pt<br>h.<br>After th<br>funeral   |                     | 27. Manner of Death 1X Natural 5 ☐ Pendi  | 28a. Date of (Month,  | Injury<br>Day Year) | 28b. Time o<br>Injury           |                                    | 28c. Injun<br>Worl   |                                      |                 | 28d. Describe                   | how inju                 | ry occurred                          |           |   |                |
| isio                |  | Icati               | 3 ☐ Suicide 6 ☐ Could   |   | f Injune - At h     | nome form of                    | M facto                            |                      | Yes 2                                | No              | 28f. Location (                 | Street ar                | nd Number o                          | r Rural   | Route Nu                                      | mher           |
| Division            | i di di  | Certification:      | 4 ☐ Homicide determ   | nined 200. Place o<br>building                              | j, etc. (Speci      | nome, farm, st<br>ify)          | reet, lacto                        | ry, once             |                                      |                 | City or To                      |                          |                                      | n nurar   | noble No                                      | mber,          |
|                     | To the Hospital within 24 hours a To the Funeral Completely filled   | edical C            |   | ng Physician: To the b<br>Examiner: On the bas<br>and manne | is of examin        |                                 |                                    |                      |                                      |                 |                                 |                          |                                      |           |   | (s)            |
|                     | To the within To the compl   | Me                  | 29b. Signature and title of certific  | 1   |                     |                                 | 2:                                 | c. License           |                                      | •               |                                 |                          | te signed (A                         |           |   |                |
| ) \                 |  |                     | e ag  | vorayo  | 10.                 |                                 |                                    | D281                 | 195                                  |                 |                                 | De                       | ec. 08                               | , 20      | 005   |                |
| 1/2                 | - (5)  |                     | 30. Name and address of person David A. Goor  | ay, M.D. 14   | 50 Me               | rcanti                          | Le La                              | ne St                | iite                                 | 217             | Largo,M                         | ary1                     | and 2                                | 0774      | 4   |                |
|                     | Sta<br>Regist  | ate<br>rar          | 31. Date filed (Month, Day, Year DEC 13   | 2005 Rec  | gistrar's Sign      | ature •                         | D                                  |                      |                                      |                 |                                 |                          |                                      |           |   |                |

|                     |   |                   | riease   | State of Manuage / Do   |   |                       | •                                  | •                    |   |
|---------------------|---|-------------------|--|---|---|-----------------------|------------------------------------|----------------------|---|
|                     |   |                   | For<br>State   | State of Maryland / De  | epartment of F<br>Sertificate of  |                       |                                    | CUUS                 | 42308   |
|                     |   |                   | Registrar     Decedent's Name (First, Middle, Last                         | <del></del>   | ertineate or  | Deairi                | 2. Date of Death                   | ġ. No.               | 3. Time of Death  |
|                     | Physici   | an                | THOMAS CORNELIU  |   |   |                       | Month<br>December                  | Day Yes              | ar M  |
|                     | /Medic<br>Examin  |                   | 4a. Facility Name (If not institution, give                                |   | 4b. City, Town, o   | r Location of Death   |                                    | 4c. County of D      | 2:36 p M  |
|                     | LXaiiiii  | C.                | Crofton Convale  |   | Crofto  | n                     |                                    | Anne Ar              | unde1   |
|                     | Funeral   |                   | 5. Social Security Number 6. Se  | x 7. Age (In yrs. last birthd   |   |                       | 8. Date of Birth<br>(Month, Day,   |                      | Birthplace (State or Foreign Country)                   |
|                     | Director  |                   | 577-28-4872  | M 2□F 82 Yrs  | 5.  |                       | Feb. 21                            |                      | irginia   |
|                     | and   | }                 | Usual Residence of Decedent  10a. State 10b. County                        | 10c. City, Town o   | r Location  |                       |                                    |                      | 10d. Inside City Limits                                 |
|                     | Manyt   | ō                 | Maryland Prince  | George's Bowie  |   |                       |                                    |                      | 1∭ Yes 2 No   |
|                     | 28a   | Director          | 10e. Street and Number   | George 3   Dowle  | 10f. Zip Code   | <del></del>           | 10                                 | g. Citizen of What   | Country?  |
|                     | h with  | 0                 | 3604 Maroon Lane   |   | 2072  | :0                    |                                    | U.S.A.               |   |
|                     | deat<br>ma  | Funeral           | 11. Marital Status   | 12. Was Decedent Ever in U.S.<br>Armed Forces?                          | 13. Was Decedent of H   |                       |                                    |                      | merican Indian,   |
| 9                   | or It   | Y.                | 1 Never Married 2 Married  | 1 XiYes 2 □ No 1942 −<br>If Yes, Give                                   | 1 ☐ Yes 2 ☒ No  | Specify:              | ,                                  | Consitu              |   |
| Maryland 21215-0036 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>Ither than "naturel", or Itema 23a or 28a-f show<br>ent, Ite Maalcal Examiner must be natified at  | d by              | 3 ☑ Widowed 4 □ Divorced   | Year or Dates: 1946   | ecedent's Usual Occup   | notion                |                                    | 16b. Kind of Busine  | White   |
| ည်                  | in 72   | ojete             | 15. Decedent's Edi<br>(Specify only highest grad                           | de completed) (C  | give kind of work done to the contract of the | during most of world) | king                               | 160. Kind of busine  | ssindustry  |
| 212                 | l with  | Completed         | Elementary/Secondary (0-12)  | College (1-4or 5+)  | nter  |                       |                                    | Merkle               | Press   |
| פַ                  | othe<br>vent,   | Be C              | 17. Father's Name (First, Middle, Last)                                    |   |   | 18. Mother's Nam      | ne (First, Middle, N               |                      |   |
| <u> a</u>           | uld b<br>Menta<br>urkad<br>utlc e   | 10                | Thomas C. Gardner  |   |   | Ade11                 | Inge Cri                           | st                   |   |
| lan.                | 2 sho<br>and<br>and<br>ls mu  | 0 8               | 19a. Informant's Name/Relationship (7)                                     |   | lailing Address (Street   |                       |                                    |                      |   |
| ≥<br>(\)            | and<br>lealth<br>m 27<br>her tr   |                   | Patricia E. McCar  | Dudgite 1   | 8 Gallery   |                       |                                    |                      |   |
| 0                   | iges 1<br>it of F<br>if ite<br>or ot  |                   | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐                    | Removal from State cemetery,  | crematory or other pla  | ce)                   |                                    | 20c. Location - City |   |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Brown injury or other traumatic event, the Marical Examinar must be notified at another. |                   | * 4 □ Donation 5 □ Other (Specify  21. Signature of Fuperal Service/Lice/6 | ^   | coln Cemete   | ry   12/1             | 3/2005                             | Brentwood            | l, Maryland   |
| E<br>E              | Dep<br>Imp<br>any   |                   | 21. Signature of 1 dyleral Service Class                                   | TY land   | 22. Name and Addre  |                       |                                    |                      | ne, P.A.<br>MD 20781                                    |
| 170                 | E-CASE  |                   | 23a. Pirt1 Enter the disease, or comp                                      | dications that cau so the death. Do not one cause on the line.          |   |                       |                                    |                      | Approximate   |
|                     | Physician   |                   | Immediate Cause (Final   |   |   |                       |                                    |                      | Interval Between<br>Onset and Death                     |
|                     | /Medical  |                   | disease or condition<br>resulting in death)                                | a. Serticemia  out to (or as a consequence of)                          | <br>:   |                       |                                    |                      | 2 weeks   |
|                     | Examiner  |                   | Conventially list panditions   | b. Decubitus Ulcers   |   |                       |                                    |                      | 5 months  |
|                     | ν =   | ner               | if any, leading to immediate cause. Enter Underlying                       | Due to (or as a consequence of)   |   |                       |                                    |                      |   |
|                     | ecute<br>and<br>-trans  | Examiner          | that initiated events<br>resulting in death) Last                          | c. Parkinsons Disea  Due to (or as a consequence of)                    |   |                       |                                    |                      | 10 Years  |
| 60,                 | eath certificate be executed<br>attending physician and<br>for use as the burial-transit  | caiE              |  |   | •   |                       |                                    |                      |   |
| 687                 | phys<br>phys<br>s the   |                   |  | d   |   |                       |                                    |                      |   |
| Box                 | nding<br>use a  | J/M               | IF FEMALE:<br>23b. Was decedent pregnant                                   | 23c. If yes, outcome of pregnancy                                       |   |                       |                                    | 23d. Date of         | delivery  |
| ň                   | death<br>e atte   | by Physician/Medi | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                   | 1 Live birth 2 Fetal death 4 Pregnant at time of death                  | 3 ☐ Ectopic pregnanc<br>5 ☐ Other (specify) _   | у                     |                                    | Month                | Day Year  |
| P.O.                | that the de<br>ad by the a<br>detached f  | hys               | 9 🗆 Unknown  | 9□ Unknown  |   |                       |                                    |                      |   |
| s,                  | 56 56   | by                | Part II. Other significant conditions co                                   | intributing to death but not resulting in the                           | ne underlying cause gr  | ven in Part I.        |                                    |                      | e to the cause of death?                                |
| Records,            | w require<br>baen si<br>should b  | ted               |  |   |   |                       | 1 ∐ Ye                             | s 2X1No 3□           | Probably 4 Unknown                                      |
| e                   | has by<br>ge 2 st   | Completed         |  |   |   |                       | 24a. Was ar<br>autops              | y prior              | autopsy findings available<br>to completion of cause of |
| <u> </u>            | cate  |                   |  |   |   |                       | 1 Yes 2                            |                      | res 2□No  |
| Viital              | iclan<br>certifi<br>rector  | Be                | 25. Was case referred to medical examiner?                                 | Hospital:   | Ott   |                       | th (Check only one                 | - American           |   |
| ō                   | Phys<br>r this<br>rat di  | 1: To             | 1 ☐ Yes 2 🔀 No<br>27. Manner of Death                                      | 28a. Date of Injury (Month, Day Year)  2 □ ER/Outp 28b. Tin             | atient 3 DOA  | 4 M Nursing H         | ome 5 ☐ Reside<br>28d. Describe ho | nce 6 Other (5       | Specify)  |
| lon                 | nding<br>Ith.<br>:: Afte<br>e fune  | atlor             | 1 XNatural 5 ☐ Pending<br>2 ☐ Accident investigation                       |   |   | rk?<br>]Yes 2 □ No    |                                    |                      |   |
| Division of         | Atte  | Certification:    | 3 Suicide 6 Could not be<br>4 Homicide determined                          | 28e. Place of Injury - At home, farm building, etc. (Specify)           | n, street, factory, office  |                       | 28f. Location (Str<br>City or Town |                      | Rural Route Number,                                     |
|                     | rs afte   | Cert              | 4  | building, etc. (Specify)  |   |                       | on, or 70m.                        | , 51010/             |   |
|                     | Hospi<br>4 hou<br>Funer<br>ely fill   | edical            |  | ysician: To the best of my knowledge, on the basis of examination and/o |   |                       |                                    |                      |   |
|                     | To the Hospital or Attending Physician: Tha I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  | Medi              | one)  29b. Signature and title of Sertifier                                | and manner stated.  | 29c. Licen:   |                       |                                    | 9d. Date signed (M   |   |
|                     | 1 vit   |                   | 250. Signature and title or continer                                       | 2000 100  | Zac. Licent   | () 0 2 9 ·            | _                                  | 17 /12 /             | A Tear)   |
| 8                   | 7) 11   |                   | 20 News and all  | y MU  | una Deign'i   | 0027                  | 7 / /                              | 1 - / 1 - /          | 05  |
| - (                 | 11 160  |                   | Paul B. Berez, M   | complete cause of death (Item 23a) (Ty  D 1655 Crofton B1               | 1 //101   | Crofton               | Maryland                           | 21114-19             | 3/12  |
|                     | Sta   | ate               | 31. Date filed (Month, Day, Year)  | Registrar's Signature   | P   | OLUI COII,            | tiat A Taila                       | <u> </u>             | J <del>T</del>  |
|                     | Regist  |                   | DEC 1 4 200  | h Male M. A.  | MARY /  |                       |                                    |                      |   |

|                |  |                   | 1 - For<br>State<br>Registrar  | State of M  | Maryland /                          |                           | artment of H                           |                    | and Men                        |   | ene                     | 5 42  | 309                                  |
|----------------|--|-------------------|--|---|-------------------------------------|---------------------------|--|--------------------|--------------------------------|---|-------------------------|---|--------------------------------------|
|                | Physicia<br>/Medic   |                   | Decedent's Name (First, Midde     PETER HUMPHRY  | dle, Last)  |                                     |                           |  |                    |                                | Date of Death<br>Month<br>CEMBER            | Day                     | Year  | ime of Death                         |
|                | Examin   |                   | 4a. Facility Name (If not institution  | on, give street and number                            | or)                                 |                           | 4b. City, Town, o                      | r Location o       |                                |   | 4c. County              |   | · JU A                               |
|                |  |                   | ANNE ARUNDEL 1   |   |                                     |                           | ANNAPOI                                |                    |                                |   |                         | ARUNDEI   |                                      |
|                | Funeral<br>Director  |                   | 5. Social Security Number 040-20-4410 Usual Residence of Decedent  | 6. Sex 7 1 X M 2 □ F                                  | Age (In yrs. last i                 | Yrs.                      | If Under 1 Year<br>Months Days         | If Under:<br>Hours | Min. (                         | Date of Birth<br>Month, Day,<br>ILY 8,      | Year)<br>1926           | 9. Birthplace (5<br>Country)<br>NY              | State or Foreign                     |
|                | yland<br>yland   |                   | 10a. State 10b. Count  | у   | 10c. City, To                       | own or Lo                 | ocation                                |                    |                                |   |                         | 10d. Ins  | side City Limits                     |
|                | a-fst  | ctor              | NJ CAMDI   | EN  | WINS                                | LOW !                     | TOWNSHIP                               |                    |                                |   |                         | 1)  | Yes 2 □ No                           |
|                | death with the Maryland<br>rms 23e or 28a-f show<br>r must be rediffed at  | Director          | 10e. Street and Number   |   |                                     |                           | 10f. Zip Code                          |                    |                                | 10  | g. Citizen of V         | Vhat Country?                                   |                                      |
|                | s 23e  |                   | 114 HAYES MILI   |   | .5                                  | 1.5                       | 08004                                  |                    |                                |   | USA                     |   |                                      |
| 21215-0036     | s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene.<br>Item 27 is marked other than "natural; or items 23e or 28a-f show other traumatic event, I'm Medical Exam are must be rediffed at | by Funeral        | 11. Marital Status  1 □ Never Married 2 □ Ma  3 ▼ Widowed 4 □ Divorce  | II Yes, Cive  | s?<br>□№ 1945-                      |                           | Was Decedent of Hif Yes, specify Cub   | an, Mexican        | gin? (Specify<br>, Puerto Rica | Yes or No-<br>n, etc.)                      |                         | e - American Ind<br>ck, White, etc.<br>:: WHITE |                                      |
| 2-0            | 72 ho  | eted              |  | ent's Education<br>est grade completed)               |                                     | Sa. Dece                  | dent's Usual Occup                     | ation              | t of working                   | 1   | 6b. Kind of Bu          | siness/Industry                                 |                                      |
| 2              | within<br>ene.<br>than "   | Completed         | Elementary/Secondary (0-12)  | College (1-4c   |                                     |                           | kind of work done<br>DO NOT use retire |                    |                                |   |                         |   |                                      |
|                | filed w<br>Hygier<br>other ti  |                   | 12<br>17. Father's Name (First, Middle   | 4   |                                     | REAL                      | ESTATE I                               | 1                  |                                |   | REAL E                  |   |                                      |
| Maryland       | ould be f<br>Mental I<br>tarked of<br>tatic eve  | ТоВе              | JAMES HUMPHRY  |   |                                     |                           |  | ELIZ               | ABETH                          | AMES  |                         |   |                                      |
| Mai            | d 2 sho<br>th and<br>7 is m<br>traum   |                   | 19a. Informant's Name/Relation   |   |                                     |                           | ng Address (Street                     |                    |                                |   |                         | State, Zip Code)                                |                                      |
|                | s 1 and strength the strength other tr   |                   | PRISCILLA HAGI 20a. Method of Disposition  | ERTY/DAUGHTE  | 20b. Place                          | of Dispo                  | MITH CT.                               |                    | RESTOWN<br>Date                |   | 08057<br>0c. Location - | City or Town, St.                               | ate                                  |
| ΘE             |  |                   | 1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (  |   | " T.FROY                            | ' P.                      | matory or other pla<br>WOOSTER         |                    | 2 /00 /2                       | 1.  |                         |   |                                      |
| Baltimore,     | in the state of  |                   | 21. Signatura to uneral Service  |   | CREMA                               |                           | 2. Name and Addre                      |                    | 2/09/2<br>y                    | 005   | ATCO,                   | NJ  |                                      |
| ä              | Depa<br>Impo<br>any i  |                   | Momes  | ( Follow)   | 10em                                | A]                        | DAMS FUNI<br>NNAPOLIS,                 | RAL &              | CREMA<br>21401                 | TION C                                      | ARE, 8                  | 14 BESTO  | GATE RD.,                            |
|                | rnysician<br>/Medical<br>Examiner  | ner               | 23a. Part1. Enfer the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | a. Due (or b. Die to (or c)                           | as a miseque                        | o not ent                 | er the mode of dying                   | ng, such as        | cardiac or res                 | spiratory arres                             | st,                     | Interv<br>Onse                                  | oximate<br>al Between<br>t and Death |
| 68760,         | ificate be executed<br>g physician and<br>as the burial-transit  | edical Examine    | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | c. Due to (or :                                       | as a consequenc                     | e of):                    |  |                    |                                |   |                         |   |                                      |
| .O. Box        | that the death certifici<br>ed by the attending pl<br>detached for use as t  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |   | 2 Fetal dea<br>at time of death     |                           | Ectopic pregnanc<br>Other (specify)    | У                  |                                |   | 23d. Dat<br>Mor         | e of delivery<br>hth Day                        | Year                                 |
| rds, P         |  | by                | Part II. Other significant condit  | / //  | but not resulting                   |                           | nderlying cause gr                     | ren in Part I.     |                                | 23e. Did toba                               | -                       | ibute to the caus                               | se of death?                         |
| Vital Records, | The la<br>ate has<br>page 2  | Completed         | ,  | ,   |                                     |                           |  |                    |                                | 24a. Was an<br>autopsy<br>perform<br>1  Yes | ed?                     | Vere autopsy fine prior to completio leath?     | n of cause of                        |
| Vita           | ician: Th<br>certificate<br>rector, pag  | Be                | 25. Was case referred to medic examiner?   | Hospital:   |                                     |                           | Ott                                    | 200                |                                | eck onlone                                  |                         |   |                                      |
| of             | ding Physician: h. After this certific funeral director,   | on: To            | 1 Yes No  27. Manner of Death  Natural 5 Pend  | 28a. Date of Ir                                       |                                     | Outpatier  Time of Injury |  | y at               | _                              |   | ce 6 Other              |   |                                      |
| Division       | i or Attending<br>after death.<br>Director: After<br>I in by the fune  | ertification;     | 3 Suicide 6 □ Could  | mined 286. Place of                                   | Injury - At home,<br>etc. (Specify) | farm, str                 | M 1<br>eet, factory, office            | Yes 2 □ !          | 28f. I                         | ocation (Stre                               | et and Numbe<br>State)  | er or Rural Route                               | Number,                              |
|                | dospital<br>4 hours<br>Funeral<br>ely filled   | edical Ce         | (Check only 2 Medica   | ing Physician: To the be<br>Il Examiner: On the basis | of examination                      | lge, deatl                | n occurred at the til                  | me, date and       | d place, and o                 | due to the cau                              | use(s) and ma           | nner as stated.                                 | use(s)                               |
|                | To the within 2. To the I complet  | Med               | one) 29b. Signature and title of certifi   | and manner  | stated.                             |                           |  |                    |                                |   |                         |   | . ,                                  |
|                | T W O  | -                 | T. Signature and title or defini   | 1   | m                                   |                           | 250. 20013                             | ~7/2               | 5                              | 29  | 2. Date signed          | 7 7 AA  | oar)                                 |
| ,              |  |                   | 30. Name and address of perso  | n who completed cause of                              | f death (Item 22                    | a) (Typo                  | Print)                                 | 165                | ,                              |   | ec v                    | ·, co   | ,                                    |
| 2              | SYL  |                   | 11m Woon   | 2001  | mali .                              | , (19pe.                  | Parleman                               | . /                | Inn.                           | 1. 2  | 1~0 2                   | 21401   |                                      |
|                | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Yea  | C - 8 200 Begi  | strari Signature                    | B                         | Print) Parkway                         | ,                  | n sir sie p                    | 7/14  | - 17 6                  |   |                                      |

|               |  |                     | For<br>State<br>Registrar  | State of M  | larylar         | nd / Depa                             | artment of h   | lealth a                           | •                                | Hygiene                              | e<br>2.005                         | 42310  |
|---------------|--|---------------------|--|---|-----------------|---------------------------------------|--|------------------------------------|----------------------------------|--------------------------------------|------------------------------------|--|
|               | Physici<br>/Medio<br>Examin  | al                  | 1. Decedent's Name (First, Middle PATMA  | ANN   |                 | 14 4                                  | 4b. City, Town, c  | or Location of                     | Mont<br>DE                       | SOMP                                 | Year Year Z O C                    | 5 17=23 M  |
|               | Funeral<br>Director  | eı                  | HARFORD ME<br>5. Social Security Number<br>215-44-1993   | MONALH  | losP.           | last birthday)<br>Yrs.                |  | E DE                               | 4 Hrs. 8. Date                   | E                                    | HARF                               |  |
|               | se Maryland<br>8a-f show   | Director            | 7  | Cecil   | 10c. Cit        | ty, Town or Lo                        | Port   | Depos                              | it                               |                                      |                                    | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No           |
| 9             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: It itam 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Exarting rutal be rediffied at Once. | Funeral             | 10e. Street and Number  89 Linton Run  11. Marital Status  1 Never Married 2 Marri   | 12. Was Decedent<br>Armed Forces  | ?               |                                       | Vas Decedent of If Yes, specify Cub                          |                                    |                                  |                                      | U.S.A  14. Race - Ame Black, White | erican Indian,                                   |
| 21215-0036    | within 72 hours<br>ene.<br>than *natural',<br>he Medical Exa   | Completed by        | 3 Widowed 4 Divorced  15. Decedent (Specify only highes  Elementary/Secondary (0-12) Twelve Years  | Year or Dates:  |                 | 16a. Dece<br>(Give<br>life.           | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | pation<br>during most<br>d)        |                                  | Con                                  | Kind of Business<br>star           | Vhite<br>√Industry<br>race,Maryland              |
| Maryland 2    | should be filed<br>nd Mental Hygi<br>markad other<br>ımatic evant, I   | To Be Co            | 17. Father's Name (First, Middle, I  J • He  19a. Informant's Name/Relationsh  | enry Schneid  | ler             |                                       | ng Address (Street   | 18. Mother                         | 's Name <i>(First, M</i><br>Etta | Gertr                                | ude Ber                            |  |
| Baltimore, Ma | ages 1 and 2 and 1 and 2 and 2 and 2 and 2 and 27 is to a cothar trau  |                     | Leonard S. Han  20a. Method of Disposition  1 \overline{\Delta} Burial 2 \overline{\text{Cremation}} \tag{Spring}  4 \overline{\Delta} Donation 5 \overline{\text{Other (Spring)}} | 3 □Removal from State   | ,   '           | 89 L:<br>Place of Disponentery, cres  |  | Road                               | , Port D                         | eposit                               | , Maryla                           | and 21904  |
| Baltir        | permit. P Departme Importan any injur  |                     | 21. Signiture of Funeral Service L   | icen ee   | DON             | S(. P                                 | Name and Addre<br>ee A. Pa<br>erryville                      | ss of Facility<br>tterso<br>e, Mar | n & Son<br>yland 2               | Funera<br>1903-0                     | al Home,                           |  |
|               | Pnysician<br>/Medical<br>Examiner  |                     | shock, or heart failure. List of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | a<br>Due to (or as  | line.           | Asc                                   |  |                                    |                                  | .,                                   |                                    | Interval Between<br>Onset and Death              |
| 68760,        | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit   | dical Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of the 1019 that initiated events resulting in death) Last                       | b. Due to (or as  |                 |                                       |  |                                    |                                  |                                      |                                    |  |
| .O. Box 6     |  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9 Unknown  | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Feta          | al death 3[                           | Ectopic pregnanc<br>Other (specify)                          | 4                                  |                                  |                                      | 23d. Date of del<br>Month          | livery<br>Day Year                               |
| S, D          | law requires that the<br>as been signed by th<br>2 should be detache   | leted by Ph         | Part II. Other significant conditio  | ns contributing to death  | but not res     | sulting in the u                      | nderlying cause gr   | ven in Part I.                     | _                                | 1 ☐ Yes 2                            | Pr⊡No 3∏Pr                         | o the cause of death?<br>robably 4 Hunknown      |
| Vital Record  | The<br>ate h<br>page   | Be Compl            | 25. Was case referred to medical   |   |                 |                                       |  | 26. Place                          |                                  | Was an autopsy performed? (es 2)2 No | prior to death?                    | utopsy findings available completion of cause of |
| Division of V | ling Phya  | Certification; To E | examiner? 1 Pres 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investig 3 Suicide 6 Could n   | ation   | ury<br>ay Year) | ER/Outpatier<br>28b. Time o<br>Injury | 28c. Inju<br>Wo<br>M 1                                       | 4 🗀 (Nu)                           | lo                               | ribe how inju                        | iry occurred                       |  |
| Divi          | To the Hospital or Atland within 24 hours after death To the Funeral Director: . completely filled in by the f   | edical Certif       | 4  Homicide determi  |   | tc. (Specif     | fy)<br>owledge, deati                 |  |                                    | City o                           | or Town, State                       | e)<br>s) and manner as             |  |
| •             | _  | Medi                | 29b. Signature and title of certifier  | and manner's  | tated.          | MOD                                   | 29c. Licens  |                                    |                                  | 29d. Da                              | ate signed (Mont                   |  |
| _             | 10   |                     | 30. Name and address of person of G-5. PNABINT   | 02336 4   | one             | c no                                  | Print)   | MOR                                | SIUM                             |                                      |                                    |  |
|               | Sta<br>Registi   |                     | 31. Date filed (Month, Day, Year) DEC 1 5 2005   | See 32. Regist  | rar's Signa     | ature                                 |  |                                    |                                  |                                      |                                    |  |

|             |   | ľ               | 1 - For<br>State<br>Registrar  | State of I  | Marylan                        |                     | artment of F<br>tificate of                                   |  | Mental Hy                         | ygien<br>Rog. N       |  | 42311  |
|-------------|---|-----------------|--|---|--------------------------------|---------------------|---|--|-----------------------------------|-----------------------|--|--|
|             | Physici<br>/Medic   |                 | Decedent's Name (First, Middle,  LARRY   | ,   | WKINS                          | SR.                 |   |  | 2. Date of D<br>Month             | D                     | )ay Year                                     | 3. Time of Death  §:53 A M                             |
|             | Examin<br>Funeral   | 3.              | ,  | give street and numb  | er)<br>Age (In yrs. i          |                     | 4b. City, Town, o  LANHAM  If Under 1 Year  Months Days       | If Under 24 Hr<br>Hours Mir                        | s. 8. Date of B                   | I<br>irth<br>Day, Yea | PRINCE GI<br>171952 9. Birtl                 | EORGE <sup>11</sup> S  pplace (State or Foreign untry) |
|             | Director  |                 | 579-74-0067           Usuaf Residence of Decedent           10a. State         10b. County   |   | 53                             | y, Town or Lo       | cation  |  | FEBRUA                            | RY 2                  | 8 Vi   | rginia  10d. Inside City Limits                        |
|             | ith the Marylan<br>or 28a-f ehow  | Director        | MD PRINCE  10e. Street and Number  | GEORGE'S  | L                              | ANHAM               | 10f. Zip Code   |  |                                   | 10g. C                | Citizen of What Co                           | 1 Yes 2 No<br>untry?                                   |
|             | th with   | a D             | 7210 LOIS LANE   |   |                                |                     | 20706   |  |                                   | ı                     | U.S.A.                                       |  |
|             | s 1 and 2 should be filed within 72 hours after death with the Maryland I Heath and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event, II.a Madical Examinational be notified at | by Funeral      | 11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced  | 12. Was Decede Armed Force at 1 Yes 2 If Yes, Give Year or Date | as?<br><b>∆</b> No             |                     | Was Decedent of H<br>f Yes, specify Cuba<br>1 ☐ Yes 2 No      | lispanic Origin? (<br>an, Mexican, Pue<br>Specify: | Specify Yes or Norto Rican, etc.) | 10-                   | 14. Race - Ame<br>Black, White<br>Specify: B |  |
| 5.0         | vithin 72 ho<br>ne.<br>hen "natur<br>e Nedicel  | Completed       | 15. Decedent'<br>(Specify only highest<br>Elementary/Secondary (0-12)  | Education<br>grade completed)<br>Coflege (1-4                   | or 5+)                         | (Give<br>life. L    | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of w<br>d)                             |                                   |                       | Kind of Business/                            | ·  |
| מומ         | ould be filed with<br>Mental Hygiene.<br>arked other ther<br>atic event, it a   | To Be Co        | 12th 17. Father's Name (First, Middle, L GAMBLE HAWKINS  | ast)  |                                | CONL                | TRUCTION  | 18. Mother's Na                                    | ame (First, Middle<br>V. PACK     | ie, Maide             |  |  |
| Maiy        | nd 2 should be alth and Mental 27 is marked or r traumatic even   | Ĭ               | 19a. Informant's Name/Relationsh DEBORAH HAWKIN  |   |                                |                     | ng Address (Street  |  |                                   |                       | or Town, State, 2                            | ip Code)   |
| Dalilliore, | permit. Pages 1 and 2<br>Department of Health a<br>Important: if Item 27 ti<br>eny injury or other tra<br><u>pnce</u> .   |                 | 20a. Method of Disposition<br>1 日 Burial — 2 図 Cremation<br>4 日 Donation ) 5 日 Other (Sp   |   | ate C                          | emetery, cren       | sition (Name of<br>natory or other place<br>CREMATO           |  | Date 17/2005                      |                       | Location - City or VERDALE, M                |  |
| Dall        | permit. Departimportimport  |                 | 21. Signature of Funeral Service L   | icensee   |                                |                     | Name and Addre  |  |                                   |                       | INS FUNER<br>MARYLAN                         |  |
|             | Physician<br>/Medical<br>Examiner   |                 | 23a. Part 1. Enter the disease, or o<br>shock, or heart failure. List of<br>fmmediate Cause (Final<br>disease or condition<br>resulting in death)          | a. CONGE  | th fine.  ESTIVE  as a consequ | HEART               | FAILURE DISEASE   | ng, such as cardi                                  | ac or respiratory                 | arrest,               |  | Approximate<br>Interval Between<br>Onset and Death     |
| ,00,0       | w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit   | edical Examiner | Sequentially flat conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or  | as a consequal as a consequal  | uence of):          | TURNO   |  |                                   |                       |  |  |
| O. DOX o    | The law requires that the death certific<br>ate has been signed by the attending page 2 should be detached for use as   | Physician/Me    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |   | h 2 □ Feta<br>It at time of d  | Ideath 3            | ]Ectopic pregnancy<br>] Other (s <i>pecify)</i>               | /  |                                   |                       | 23d. Date of deli<br>Month                   | very<br>Day Year                                       |
| Colds, T.   | uires that<br>signed by<br>d be deta  | b               | Part II. Other significant condition HYPERTENSION  | ns contributing to deat   | th but not res                 | ulting in the u     | nderlying cause giv   | ren in Part I.                                     |                                   |                       |  | the cause of death?                                    |
| ב           | ding Physician: The law rec<br>h.<br>After this certificate has beei<br>funeral director, page 2 shou   | Completed       | DIABETES   |   |                                |                     |   |  | 24a. Wa<br>aut<br>per<br>1 🗆 Yes  | opsy<br>formod?       | prior to death?                              | topsy findings available completion of cause of        |
|             | sian:<br>artifica<br>ictor, p   | Bec             | 25. Was case referred to medical examiner?   |   |                                |                     |   |  | eath (Check only                  |                       |  |  |
| 5           | Physician:<br>r this certificated director, iral  | 2               | 1 ☐ Yes 2 ♣ No   | Hospital: 1 Inp   |                                | ER/Outpatien        |   | 4   Nursing  |                                   |                       | 6 □Other (Spec                               | eify)  |
| VISION      | Attending F<br>death.<br>ctor: After<br>y the funer   | Certification:  | 27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n  | ation ot be   | Day Year)                      | 28b. Time of Injury | Wor   | y at<br>k?<br>Yes 2 □ No                           | 28d. Describe                     |                       | fury occurred and Number or Ru               | ral Route Number                                       |
| 2           | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: Attencompletely filled in by the fune   |                 | 4 ☐ Homicide determi  29a. Certifier 1 △ Certifying  | building Physician: To the be                                   | , etc. (Specif                 | y)<br>              |   | me, date and plac                                  | City or T                         | own, Sta              | nte)   |  |
|             | he Ho<br>in 24 h<br>he Fu   | edical          |  | xaminer: On the bas<br>and manne                                | is of examina                  |                     |   |  |                                   |                       |  |  |
|             | with Com  | Σ               | 29b. Signature and title of certifier  |   | MO                             |                     | 29c. Licens   | 00556 9  | 7                                 |                       | Date signed (Mont)                           |  |
| /           | (3)   |                 |  | inarh   | UU.                            | MP                  | 575 MAIN  | STREET   | # 351 L                           | AURE                  | L,MARYLA                                     | ND 20707   |
|             | Sta<br>Registi  |                 | DEC 1 6  | 2. Reg  | gistrar's Signa                | ture                | W   |  |                                   |                       |  |  |

DHMH 17 Rev 1/2001

Hawkins, Larry S.

|                     |   |                       | 1 - For<br>State<br>Registrar  | State of Maryl   |   | artment<br>rtificate                       |                     |                           | and M                   | _                                      | giene                              | 5 1                               | +2312  |
|---------------------|---|-----------------------|--|--|---|--|---------------------|---------------------------|-------------------------|--|------------------------------------|-----------------------------------|--|
|                     | Physici   | an                    | Decedent's Name (First, Middle, Last     JOHNNIE J   |  |   |  |                     | -                         |                         | 2. Date of De<br>Month                 | Dav                                | Year                              | 3. Time of Death                                   |
|                     | /Medio<br>Examin  |                       | JOHNNIE J  4a. Facility Name (If not institution, give PRINCE GEORGE 1)  | street and number)   |   | 4b. City, To                               | own, or i           |                           | f Death                 | DECEM                                  | 4c. Count                          |                                   | GEORGE'S   |
|                     | Funeral   |                       | Social Security Number 6. S  | 7. Age (In )   | rs. last birthday)                                | If Under 1                                 | Year                | If Under 2                | 24 Hrs.                 | 8. Date of Bin                         |                                    |                                   |  |
|                     | Director  |                       | Usual Residence of Decedent  | 2 M 2 □ F   76   | Yrs.  |  | Days                | Hours                     | Min.                    | 8. Date of Bir<br>(Month, Da<br>OCTOBE | R 31                               | NOR'                              | lace (State or Foreign<br>try)<br>I'H CAROLINA     |
|                     | with the Marylar<br>a or 28a-f ahow<br>be rediffed at   | Director              | 10e. Street and Number   | GEORGE'S   | GLENA   | RDEN<br>10f. Zip C                         |                     |                           |                         |  | 10g. Citizen of                    |                                   | 0d. Inside City Limits 1 X Yes 2 □ No try?         |
| 9000                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f ahow any Injury or other traumatic avent, The Medical Examinar must be redilled at once. | d by Funeral Director | 7900 JOHNSON A   | 12. Was Decedent Ever i<br>Armed Forces?<br>1 XYes 2 ☐ No<br>If Yes, Give<br>Year or Dates:  | ARMY I  |  |                     | panic Orig<br>, Mexican,  | gin? (Spe<br>, Puerto F | cify Yes or No<br>Rican, etc.)         | U.S.<br>14. Rad<br>Bla<br>Specif   | ce - Americ<br>ck, White, e<br>y: |  |
| 1215-               | within 72 tiene.<br>than "nati  | Completed             | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>12th  | ucation<br>de completed)<br>College (1-4or 5+)   | (Give   | dent's Usual<br>kind of work<br>DO NOT use | done du<br>retired) | iring most                |                         | ng                                     | 16b. Kind of B                     | usiness/Ind                       | lustry   |
| Maryland 21215-0036 | uld be filed<br>Aentai Hygi<br>rked other<br>itic avent, II   | To Be C               | 17. Father's Name (First, Middle, Last)  JOHN HERRING  |  | , 322   | 0111201                                    |                     |                           | r's Name                | (First, Middle,                        | Maiden Sumar                       |                                   |  |
|                     | and 2 should is should in 27 is marke ier traumatic   |                       | 19a. Informant's Name/Relationship (7<br>BETTY J. HERRING/   |  |   |  |                     |                           |                         |  | or, City or Town<br>N, MARYL       |                                   |  |
| Baltimore,          | Pages 1<br>ment of He<br>ant: If Itan<br>lury or oth  |                       | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □  1 4 □ Donation 5 □ Other (Specify  | Removal from State   | b. Place of Dispo<br>cemetery, created<br>HARMONY | matory or oth                              | er place,           |                           | 12/16                   | o/05                                   | 20c. Location                      |                                   |  |
| Ball                | permit.<br>Departi<br>Import.<br>any Inj<br>once.   |                       | 21. Signature of Funeral Service Licen   | all  |   |  | AND                 | OVER                      | ROAD                    | LANDO                                  | NKINS FI<br>VER, MAI               | JNERAI<br>RYLANI                  | L HOME<br>D 20785                                  |
|                     | Physician   |                       | 23a. Part1. Enter the disease, or comp<br>shock, or heardrailure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)       | one cause on each line.  | eath. Do not en                                   |  | of dying,           | , such as o               | cardiac or              | respiratory ar                         | rest,                              |                                   | Approximate<br>Interval Between<br>Onset and Death |
|                     | /Medical<br>Examiner  | -                     |  | b. Due to (or as a condition of the cond | EBRAL MI  | ETASTAS                                    | SIS                 |                           |                         |  |                                    |                                   |  |
| 8760,               | ate be executed thysician and the burial-transit  | dicai Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | CINOMA (  | OF COL                                     | ON                  |                           |                         |  |                                    |                                   |  |
| P.O. Box 68         | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | Physician/Med         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of   | etal death 3[                                     | Ectopic preg                               |                     |                           |                         |  |                                    | te of deliver                     | y<br>Day Year                                      |
|                     | quires that<br>n signed by  | b                     | Part II. Other significant conditions of   | ontributing to death but not   | resulting in the u                                | nderlying cau                              | ise giver           | in Part I.                |                         |  | _                                  |                                   | e cause of death?                                  |
| al Records,         |   | Completed             |  |  |   |  |                     |                           |                         |  | rmed?                              | prior to com<br>death?            | sy findings available apletion of cause of         |
| Vita                | sician<br>certifi<br>rector   | Be c                  | 25. Was case referred to medical examiner?   | Hospital:  | 200   |  | Other               |                           |                         | (Check only o                          |                                    |                                   |  |
| Division of         | Attanding Physician: The Ir death. r death. actor: After this certificate hactor. After this certificate hay the funeral director, page   | ition; To             | 1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year  | 28b. Time o<br>Injury                             |  | injury a<br>Work?   | 4 🗀 IVUI:                 | 2                       |  | lence 6 Oth                        |                                   | )  |
| Divisi              | al or Attanos after deati   | Certification;        | 3 Suicide 6 Could not be determined  |  | at home, farm, str<br>ecify)                      |  |                     |                           |                         | 8f. Location (S<br>City or Tow         | Street and Numb<br>m, State)       | er or Rural                       | Route Number,                                      |
|                     | To the Hospital or Attand within 24 hours after death To the Funeral Diractor: completely filled in by the  | Medicai C             | 29a. Certifier 1 Certifying Ph. (Check only one) Medical Exam  | ysician: To the best of my<br>iner: On the basis of exam-<br>and manner stated.  | knowledge, deati                                  | n occurred at<br>vestigation, in           | the time            | , date and<br>nion, death | piace, an               | nd due to the o                        | cause(s) and ma<br>date and place, | anner as sta<br>and due to        | ited.<br>the cause(s)                              |
|                     | To the within 2 To the complet  | Σ                     | 29b. Signature and title of certifier  |  |   | 29c. I                                     | icense i            | number                    |                         |  | 29d. Date signe                    | d (Month, D                       | ay, Year)  |
| Λ                   |   |                       | 30 N/m 13  | nomploted assessed to a second   | In 20-1 7   |  | 3106                | 9                         |                         |  | Dece                               | mber .                            | 13, 2005   |
| X                   | - 0   |                       | 30. Name and address of person who of GEORGE BONE M. 1   |  |   | •  | 135                 | 5 LAR                     | .GO,                    | MARYLAI                                | ND 207                             | 74                                |  |
|                     | Sta<br>Registr  |                       | 31. Date filed (Month, Day, Year)  DEC 1 6 200   | 3 Registrar's Si   | gnature   |  |                     |                           |                         |  |                                    |                                   |  |

|                     |  |                 | 1 - For<br>State<br>Registrar  | State of Maryla  |                        | artment of H                             |                                       | _                                     | giene<br>Reg. No. 005                | 42313   |
|---------------------|--|-----------------|--|--|------------------------|--|---------------------------------------|---------------------------------------|--------------------------------------|---|
| 2                   | Physici  | an              | Decedent's Name (First, Middle, Last,  |  | - Ll- 172              |  |                                       | 2. Date of De<br>Month                | Day Yea                              |   |
|                     | /Medio   |                 | 4a. Facility Name (If not institution, give  | Jean Elizabe   | etn Hin                | es<br>4b. City, Town, o                  | r Location of Oca                     | Decemb                                | er 13, 200<br>4c. County of De       |   |
| 1                   | Examir   | er              | Anne Arundel Med   |  |                        | Annapo                                   |                                       | iui                                   | Anne Ar                              |   |
| ¥                   | Funeral<br>Director  |                 | 023-30-0506  | 7. Age (In yrs   | last birthday)<br>Yrs. | If Under 1 Year<br>Months Days           | If Under 24 Hr<br>Hours Mir           |                                       | IX. Year O                           | Birthplace (State or Foreign<br>Country)<br>SSACHUSETTS |
|                     | land   |                 | Usual Residence of Decedent  10a. State 10b. County  | 10c. C   | ity, Town or Lo        | cation                                   |                                       |                                       |                                      | 10d. Inside City Limits                                 |
|                     | Mary<br>I eh   | tor             | Md. Prince G   | æorges B   | owie                   |  |                                       |                                       |                                      | 1 ŽYes 2 No   |
|                     | or 28a   | Director        | 10e. Street and Number   |  |                        | 10f. Zip Code                            |                                       |                                       | 10g. Citizen of What                 | Country?  |
|                     | th wit   | alD             | 12500 Madeley Lar  | ıe   |                        |  | 20715                                 | ,                                     | USA                                  |   |
|                     | er dea   | Funeral         | 11. Marital Status   | 12. Was Decedent Ever in t<br>Armed Forces?            |                        | Was Decedent of H                        | ispanic Origin? (<br>In, Mexican, Pue | Specify Yes or No<br>rto Rican, etc.) | 14. Race - Ar<br>Black, W            | nerican Indian,<br>hite, etc.                           |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland nat Hygiene.  do other then "neturel", or items 23a or 28a-f ehow event, the Madical Examinar must be notified at | by              | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 🛣 No<br>If Yes, Give<br>Year or Dates:       |                        | 1 ☐ Yes 2⊠ No                            | Specify:                              |                                       | Specify: W                           | Mhite   |
| 2-0                 | 72 ho  | Completed       | 15. Decedent's Edu<br>(Specify only highest grad   |  | 16a. Dece              | dent's Usual Occup                       | ation                                 | orkina                                | 16b. Kind of Busines                 |   |
| 121                 | within<br>ene.<br>then   | mpl             | Elementary/Secondary (0-12)  | College (1-4or 5+)                                     | life.                  | DO NOT use retired                       | 1)                                    |                                       | Elementary                           | Cohool  |
| d<br>2              | filed v<br>Hygie<br>other t  | e Co            | 17. Father's Name (First, Middle, Last)  | 4  | Teac                   | cher                                     | 18 Mother's Na                        |                                       | , Maiden Sumame)                     | SCHOOL  |
| an                  | Mental<br>Mental<br>arked o  | To Be           |  | ames Joseph H  | artnett                | _  |                                       |                                       | Howley                               |   |
| ary                 | g p E E  | -               | 19a. Informant's Name/Relationship (Ty   | _  |                        |  | and Number or F                       |                                       | er, City or Town, State              | , Zip Code)   |
|                     | and 2<br>salth a<br>n 27 ls  |                 | William E. Hines   |  | d 1250                 | 00 Madele                                | y Lane,                               | Bowie, M                              | aryland 20                           | 715   |
| Baltimore,          |  |                 | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F  |  | Place of Dispo         | sition (Name of<br>matory or other place | e)                                    | Date                                  | 20c. Location - City                 |   |
| E E                 | rtmen<br>rtent:<br>njury   |                 | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fune S → Vice License   |  |                        | l Cemeter                                |                                       |                                       |                                      | . Massachusett  |
| Ba                  | permit. Page<br>Department of<br>importent: if<br>eny injury or<br>once.   |                 | 21. Signature of Fune 15 lice Licens   | M Lall   |                        | 2. Name and Addres                       | 1                                     |                                       | neral Home                           |   |
|                     |  |                 | 23a. Part1. Enter the disease, or compli   | ications that caused the dea                           | ith. Do not ent        | er the mode of dyin                      | Crain Ho<br>g, such as cardia         | VY . , BOW                            | ie, Marylar                          | Approximate   |
|                     | Physician  |                 | shock, or heart failure. List only or<br>Immediate Cause (Final  |  | -Node                  | V: IC L.                                 | ola ac                                | C. 10                                 | 41- 4- 10                            | Interval Between<br>Onset and Death                     |
|                     | /Medical   |                 | disease or condition resulting in death)   | Due to (or as a conse                                  | quence of):            | Fire Can                                 | mprioria                              | Entrop                                | athy-type                            | month   |
|                     | Examiner   |                 | Sequentially list conditions,  | D  |                        |  |                                       |                                       |                                      |   |
|                     | ed tis   | lne             | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a conse                                  | quence of):            |  |                                       |                                       |                                      |   |
|                     | be executed<br>Icien and<br>burial-translt   | Examine         | that initiated events<br>resulting in death) Last  | Due to (or as a conse                                  | quence of):            |  |                                       |                                       |                                      |   |
| 8760,               | cate be executed physicien and the burial-transit  | dlcal E         | L.   |  | ,                      |  |                                       |                                       |                                      |   |
| 9                   | tificate<br>ig phy<br>as the   | ledic           |  | 1.   |                        |  |                                       |                                       |                                      |   |
| Вох                 | eath certific<br>ettending p   | an/N            | 230. Was decedent pregnant   | 3c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet |                        | Ectopic pregnancy                        |                                       |                                       | 23d. Date of c                       | lelivery  |
|                     | the death certificate<br>y the ettending physi<br>iched for use as the   | by Physician/Me | in the past 12 months?  1 Yes 2 DNo 9 Unknown  | 4☐ Pregnant at time of<br>9☐ Unknown                   |                        | Other (specify)                          |                                       |                                       | Month                                | Day Year  |
| P.0                 | thet the de<br>ed by the<br>detached   | Ph)             | Part II. Other significant conditions cor  | ntributing to death but not re                         | sulting in the u       | nderlying cause givi                     | an in Part I                          | 23a Did t                             | obacco use contribute                | to the cause of death?                                  |
| Vital Records,      | es<br>Pe   |                 |  |  |                        | , and a second of the                    |                                       | 1 🗆 '                                 |                                      | Probably 4 Unknown                                      |
| Ö                   | s been s<br>s been s<br>s should   | Completed       |  |  |                        |  |                                       | 24a. Was                              | an 24b. Were                         | autopsy findings available                              |
| 2                   | The lav  | mo              |  |  |                        |  |                                       |                                       | prior to death'                      | o completion of cause of                                |
| ta                  |  | Be C            | 25. Was case referred to medical examiner?   | Allalid -  |                        | 7:01                                     | 26. Place of De                       | 1 ☐ Yes<br>eath (Check only o         |                                      | es 2   No   |
| <b>o</b>            | Physician:<br>this certific<br>ral director.   | 안               | 1 ☐ Yes 2 No   | lospital: 1 Inpatient 2                                | ] ER/Outpatier         | t 3□ DOA Oth                             | er: 4 🗆 Nursing                       | Home 5 ☐ Resid                        | dence 6 Other (Sp                    | pecify)   |
| Z C                 | ling P   | inol            | 27. Manner of Death 1. Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)               | 28b. Time of<br>Injury | Worl                                     |                                       | 28d. Describe I                       | now injury occurred                  |   |
| Division            | Attending r death. actor: After y the fune   | lcat            | 2 Accident investigation 3 Suicide 6 Could not be  | 28e Place of Injury . At I                             | nome form etc          |  | Yes 2 □No                             | 29f Location /                        | Street and Number                    | Overt Basses March                                      |
| <u>≤</u>            | after<br>after<br>Direct   | Certification:  | 4 Homicide determined  | 28e. Place of Injury - At I<br>building, etc. (Spec    | ify)                   | eet, ractory, office                     |                                       | City or Tov                           | Street and Number or .<br>wn, State) | Hurai Houle Number,                                     |
|                     | To the Hospital or Attending Phys within 24 hours alter death. To the Funeral Director: After this completely filled in by the funeral directors.                        |                 | 29a. Certifier 1X Certifying Phys  | sician: To the best of my kn                           | owled ja death         | occurred at the tim                      | is, date and plan                     | a, and due to the                     | cause(s) and manner                  | ae etetad.  |
|                     | the Horin 24<br>the Fu   | edical          |  | ner: On the basis of examin and manner stated.         |                        |  |                                       |                                       |                                      |   |
|                     | To T<br>com  | Σ               | 29b. Signature and title of certifier  | our mo   |                        | 29c. License                             | number                                |                                       | 29d. Date signed (Mo.                | nth, Day, Year)   |
|                     | (10)   |                 | Januare W.   |  |                        | 105                                      | 2850                                  |                                       | DECEMBE                              | 17,2005   |
| 1-                  | -(10)  |                 | 30. Name and address of person who co  | mpleted cause of death (Ite                            | m 23a) (Type,          | Print)                                   | #3,20 4                               | tunner.                               | LIC MD                               | 7.16.21   |
|                     | Sta  | te              | 31. Date filed (Month, Day, Year)  | 2. Registrar's Sign                                    | ature                  | 47(1000)                                 | -7/                                   | The state of                          | 113/100                              | 0.701   |
|                     | Registr  |                 | 29b. Signature and title of certifier  Jewise W  30. Name and address of person who co  Jewise Weyn  31. Date filed (Month, Day, Year)  DEC 1 6 2005 | Book &   | Spine                  | Be .                                     |                                       |                                       |                                      |   |

|                     |   | 1                |   | partment of Health and Me<br>ertificate of Death  | ental Hygie                                      | 711115   | 42314  |
|---------------------|---|------------------|---|---|--|--|--|
|                     | Dhysisis  |                  | Decedent's Name (First, Middle, Last)   |   | 2. Date of Death<br>Month                        | <sup>Day</sup> , 2005  | 3. Time of Death                                   |
|                     | Physicia<br>/Medic  | al .             | Jehu C. Hunter  |   | December   | /, 2005  | 12:17A™  |
| -                   | Examin  | er               | 4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital  | 4b. City, Town, or Location of Death  Laurel  |  | Prince G   |  |
|                     | Funeral   |                  | Social Security Number     6. Sex     7. Age (In yrs. last birthda  |   | 8. Date of Birth                                 |  | nolace (State or Foreign                           |
|                     | Director  |                  | 579 <b>−</b> 16 <b>−</b> 4525   | Months Days Hours Min.  | B. Date of Birth<br>(Month, Day, Ye<br>larch 11, | 1922 Wa  | shington DC  |
|                     | and .   | -                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  | Location  |  |  | 10d. Inside City Limits                            |
|                     | Maryli<br>ind a   | to               | Maryland Prince George's  | Chapel Oaks   |  |  | 1X Yes 2 □ No                                      |
|                     | h the   | irec             | 10e. Street and Number  | 10f. Zip Code   | 10g.   | Citizen of Whal Co   |  |
|                     | be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or itams 23s or 28s-f show svant. The Madical Exertainer must be notified at  | Funeral Director | 1207 Farmingdale Avenue   | 20743   |  | USA  |  |
|                     | er dez<br>Itama   | nue              |   | <ol> <li>Was Decedent of Hispanic Origin? (Spec<br/>If Yes, specify Cuban, Mexican, Puerto R</li> </ol> | cify Yes or No-<br>lican, etc.)                  | 14. Race - Ame<br>Black, White   |  |
| 36                  | irs aft   | by F             | 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: WWII                                    | 1 ☐ Yes 2X No Specify:  |  | Specify: B1  | ack  |
| 9                   | 2 hours   | ted              | 15. Decedent's Education 16a. De<br>(Specify only highest grade completed) (Gi  | cedent's Usual Occupation ve kind of work done during most of working                                   | g 16t  | o. Kind of Business/   | Industry   |
| 21                  | ithin 7<br>ne.<br>han "r  | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)  | a. DO NOT use retired)  |  | Governm  | ont  |
| 121                 | filed w<br>Hygier<br>other tl   | e Co             | 6+  | Biologist  18. Mother's Name  | (First, Middle, Mai                              |  | CITC   |
| lano                | Aental I  | To Be            | Jehu L. Hunter  |   | Callis   |  |  |
| Maryland 21215-0036 | s 1 and 2 should<br>f Health and Men<br>Item 27 is marks<br>other traumstic   |                  | 19a. Informant's Name/Relationship (Type, Print)  Edith Francis Hunter (Wife)  19b. Ma 120  | ailing Address (Street and Number or Rural<br>1)7 Famingdale Avenu                                      | Route Number, C<br>le, Chape                     | ity or Town, State, 2<br>1 Oaks, M   | (ip Code)<br>ID 20743                              |
| Baltimore,          | Pages 1 ament of Hestant: If Item   |                  | 20a. Method of Disposition  12 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)                                      | position (Name of rematory or other place) ran's Cemetery 12/16   |  | c. Location - City or<br>heltenham   |  |
| Balti               | permit. Departm Importal any inju   |                  | 21. Signature of Funeral Service Licensee   | 22. Name and Address of Facility Lati<br>6906 Kent Town Driv  |  |  |  |
|                     | 5 4   |                  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. | enter the mode of dying, such as cardiac or   | respiratory arrest                               | ,  | Approximate<br>Interval Between<br>Onset and Death |
| 18                  | Physician<br>/Medical   |                  | Immediate Cause (Final disease or condition resulting in death)   | al failure  |  | all of the state o |  |
|                     | Examiner  |                  | Due to (or as a consequence or):  |   |  | And a second control of the second control o |  |
| - E                 | D #   | Iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)        | rental stali  |  |  |  |
|                     | be executed<br>iicien and<br>burial-transit   | Examine          | that initiated events resulting in death) Last  Due to (or as a consequence of):  | rental premi  | 7  |  |  |
| 760,                | O 42 O  | caiE             | 1 Hyperkal  | euro.   |  |  |  |
| 68                  | rtificat<br>ng phy<br>s as th   |                  | IF FEMALE:  |   |  | <u></u>  |  |
| .O. Box             | The law requires that the death certificate the bas been signed by the attending phypage 2 should be detached for use as the  | Physician/Med    | 23c. If yes, outcome of pregnancy   | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)  |  | 23d. Date of del<br>Month  | ivery<br>Day Year                                  |
| α.                  | s that I<br>ned by<br>e detai   |                  | Part II. Other significant conditions contributing to death but not resulting in the  | e underlying cause given in Part I.   | 23e. Did tobac                                   | cco use contribute to  | the cause of death?                                |
| rds                 | w requires<br>been sign<br>should be  | ed b             | Dementia  |   | 1 🗌 Yes  | 2 □ No 3 □ Pr  | obably 4 Honknown                                  |
| Records,            | as be   | Completed by     | Dehydration   |   | 24a. Was an autopsy                              | prior to   | topsy findings available completion of cause of    |
| E R                 | rsicien: The law<br>s certificate has t<br>director, page 2 s   | Соп              | Abnormal electrolyte, Hypotension   |   | performe<br>1 ☐ Yes 2 등                          |  | 2 □ No   |
| Vital               | lclen<br>certifi<br>rector  | Be               | 25. Was case referred to medical examiner?  Hospital:   | 26. Place of Death  |  | 2 Floring (Com-  | -6.1   |
| of                  | <b>E</b> = 0  | To To            | 1 ☐ Yes \$₽No ☐ Inpatient 2 ☐ ER/Outpa  27. Mannac of Death 28a. Date of Injury 28b. Tim  | e of 28c. Injury at 2   | 8d. Describe how                                 | be 6 Other (Spe<br>injury occurred   | City)  |
| ion                 | nding<br>ath.<br>r: Afte<br>e fune  | atlor            | Natural 5 ☐ Pending (Month, Day Year) Inju  | ry Work?<br>M 1 ☐ Yes 2 ☐ No  |  |  |  |
| Division            | or Attender<br>offer designation of the control of the | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)                                     | street, factory, office 2   | 8f. Location (Stree<br>City or Town, S           | et and Number or Ri<br>State)  | ural Route Number,                                 |
|                     | To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,   | edical Ce        | 29a. Certifier (Check only one)  Certifying Physician: To the basis of examination and/o and manner stated.                               | eath occurred at the time, date and place in<br>r investigation, in my opinion, death occurre           | and due to the caused at the time, date          | ea(c) and manner as<br>and place, and due  | e to the cause(s)                                  |
|                     | To the within 2 To the complet  | Me               | 29b. Signature and title of certifier   | 29c. License number D 55403   |  | Date signed (Mont  | , ,  |
| 2                   | (3) 1Va   |                  | 31 Name and address of person who completed cause of death (Item 23a) (Ty 7610 SULLEY K. SHETHY, MD.                                      | PE, Print) TAKOMA FAKK  | MD 20  | 912  |  |
| i                   | St<br>Regist  | ate<br>rar       | 31. Date filed (Month, Day, Year) 22. Registrar's Signature  DEC 1 2 2005   |   |  |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy Alberta Hollingsworth /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Memoria Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 ☐ M 2 ☐ xF 215-26-4725 76 Director August 3, 1929 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. sm 27 is marked other then "natural", or Itams 23a or 28a-1 show ther traumatic avant, Ita Nedicial Exemplar must be notified at 1 ☐ Yes 2 ☐ No Directo Caroline Denton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10928 Log Cabin Road 21629 United States of America by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Marned Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates Caucasian Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be Willie Sard Carroll Louise Marvel other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 ment of Health a ant: If Itsm 27 ls 10928 Log Cabin Road, Denton, Maryland Dan D. Hollingsworth, III Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DyBurial 2 Cremation 3 Removal from State injury or Department Important: If sny injury or Denton Cemetery 4 ☐Donation 5 ☐ Other (Specify) 12/20/2005 Denton, Maryland 21. Signature of Funeral 23. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 su 1000 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Reval Acu-es disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bolic Ta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medicai Examiner per The law requires that the death certificate be executed 1ca/e use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month ŏ Year Day 4☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 🙀 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Withnown Completed should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) SANO 2 ER/Outpatient 3□ DOA P 1 🗌 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / filled in by the f 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral Completely fitled i Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO073110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis DeShield, M.D., 219 South Washington Street, Easton, Maryland 21601

Date filed (Month, Day, Year)

32, Registrar's Signalere 31. Date filed (Month, State Registrar

|            |  |                | 1 - For<br>State<br>Registrar  | State                        | of Marylai   | •                                | artment of H  |                              | nd Menta                          |                           | ene 0 C                      | 5 1                     | 2316                                      |
|------------|--|----------------|--|------------------------------|--|----------------------------------|---|------------------------------|-----------------------------------|---------------------------|------------------------------|-------------------------|---|
| ě          | Physici  | an             | 1. Decedent's Name (First, Middle Robert A. Harn   |                              |  |                                  |   |                              | 2. Date<br>Mor                    | of Death                  | Day                          | Yeer                    | 3. Time of Death                          |
|            | /Medi  | cal            | 4a. Fecility Name (If not institution  |                              | umber)   |                                  | 4b. City, Town, or  | r Location of                |                                   | mber                      | 12<br>4c. County             | 2005                    | 11:20 A <sup>M</sup>                      |
|            | Examir   | ier            | Anne Arundel M   |                              |  |                                  | Annapol:  |                              | Death                             |                           |                              | Aruno                   | le1                                       |
|            | Funeral  |                | 5. Social Security Number  | 6. Sex<br>1 <b>⊠</b> M 2 ☐ F |  | . last birthday)                 | If Under 1 Year<br>Months Days                                    |                              |                                   | of Birth                  |                              |                         | ace (State or Foreign                     |
| tgi.       | Director   | į.             | 190-16-0420 Usual Residence of Decedent  | 1251111                      | 81   | Yrs.                             |   |                              | Nov                               | . 3,                      | 1924                         |                         | ylvania                                   |
|            | yland<br>how   |                | 10a. State 10b. County   |                              |  | ity, Town or Lo                  |   |                              |                                   |                           |                              | 10                      | d. Inside City Limits                     |
|            | Ba-fa  | Director       |  | Arunde1                      | Aı   | nnapoli                          |   |                              |                                   |                           |                              |                         | txChres 2 □ No                            |
|            | a or 2   | Dire           | 10e. Street and Number  201 Woods Driv   |                              |  |                                  | 10f. Zip Code 21403   |                              |                                   |                           | g. Citizen of                |                         |   |
|            | ms 23  | Funerai        | 11. Marital Status   | 12. Was De                   | cedent Ever in U   |                                  | Was Decedent of Hi  | ispanic Origi                | in? (Specify Yes                  | s or No-                  |                              | e - Americe             | n Indian,                                 |
| ٥          | be filed within 72 hours after deeth with the Marylan<br>tal Hygiene.<br>d other than "natural", or items 23a or 28a-f ahow<br>event, the Medical Examaner oual be notified at   | / Fur          | 1 ☐ Never Married 20014Marr  | ied 1 Yes                    | 2 No   |                                  | If Yes, specify Cuba<br>1 □ Yes 2 ☑ No                            | in, Mexican, i<br>Specify:   | Puerto Rican, e                   | itc.)                     | Specif                       | ck, White, et<br>v: whi |   |
| 9500-61212 | hours<br>lural',   | d by           | 3 Widowed 4 Divorced   | Year or                      | Dates:1942-  | -1945                            |   |                              |                                   |                           |                              |                         |   |
| Ş          | in 72<br>n "net  | Completed      | 15. Decedent<br>(Specify only highes   | st grade completed           |  | (Give                            | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired | ation<br>during most o<br>f) | of working                        | 1                         | 6b. Kind of B                | usiness/Indi            | istry                                     |
| 717        | giene.   | Com            | Elementary/Secondary (0-12)  | 4                            | (1-4or 5+)   | Phar                             | macist  |                              |                                   | ]                         | Pharma                       | су                      |   |
|            | be file<br>tal Hy<br>d oth   | Be             | 17. Father's Name (First, Middle,  | Last)                        |  |                                  |   |                              | s Name (First,                    |                           | a <i>iden Sum</i> an         | ne)                     |   |
| Maryland   | es 1 and 2 should be filed within 72 hours after deeth with the Maryland of Heatih and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ahow rother trans and the most second to the control Exam her must be notified at | ٦              | Ralph Harnish  19a. Informant's Name/Relations   | hin (Tuna Print)             |  | 10b Maili                        | ng Address (Street a  |                              | Humphre                           |                           | City of Tour                 | State 7in /             | Sada l                                    |
| <u>8</u>   | nd 2 sullth an 27 ls r traur   |                | David Harnish/   |                              |  |                                  | Wainwrigh   |                              |                                   |                           |                              |                         | <i>,</i> 00e)                             |
| ē,         | of Health a litem 27 is  | 1 3            | 20a. Method of Disposition   | - 7                          |  | Place of Dispo                   | sition (Name of matory or other place                             | (e)                          | Date                              | 2                         | 0c. Location                 | City or Tow             | m, Slate                                  |
| Ē          | Page<br>ment cant: If<br>ant: If<br>ury or   |                | 1 ☐Burial 2 ☐ Cremation  1 ☐ Burial 2 ☐ Cremation  1 ☐ Other (S  |                              | n State  | llcrest                          | Cemetery  | 7 1:                         | 2-14-20                           |                           | Annapo:                      |                         |   |
| Baitimore, | permit. Pages I<br>Department of H<br>Important: If Ite<br>any injury or ot<br>once.   |                | 21. Signature of Funeral Service   | Licensee<br>Romano           | ki   |                                  | 2. Name and Address 7. Duke of                                    |                              |                                   |                           |                              |                         | Home, Inc<br>D 21401                      |
| 8/60,      | death certificate be executed  e attending physician and e attending physician and dor use as the burial-transit   | dical Examiner | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Juliane of the Indiated events resulting in death) Last | b. Due to                    | o (or as a conse   | quence of):                      | Fibv  | St                           | 1                                 |                           |                              |                         |   |
| O. Box 6   | death certifi<br>e attending I<br>id for use as  | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 1 Live                       | utcome of pregn<br>birth 2 Fet<br>gnant at time of<br>mown | al death 3                       | Ectopic pregnancy Other (specify)                                 |                              |                                   |                           |                              | te of delivery          | day Year                                  |
| ds, P      | ss tha   | by             | Part II. Other significant condition   | ons contributing to          | death but not re   | sulting in the u                 | nderlying cause give  | en in Part I.                | 236                               | . Did toba<br>1 □ Yes     |                              |                         | cause of death?                           |
| Hecord     | e law<br>has b   | ompleted       |  |                              |  |                                  |   |                              | _   _                             | . Was an autopsy performe | ed?                          | prior to comp<br>death? | sy findings available pletion of cause of |
| VItal      | ician: Th<br>certificate<br>rector, pag  | Be C           | 25. Was case referred to medical examiner?   |                              |  |                                  |   | 26. Place o                  | of Death (Check                   |                           |                              | 10165 2                 |   |
| 0          | Physician:<br>this certific<br>ral director,   | မ              | 1 ☐ Yes 2 ☑ No   | Hospital:                    |  | ER/Outpatier                     |   | 4 🗆 14012                    | sing Home 5                       |                           |                              |                         |   |
|            | fing<br>I.<br>After<br>Fune  | ion:           | 27. Manne of Death Natural 5 Pendin  | g (Mc                        | e of Injury<br>onth, Day Year)                             | 28b. Time o<br>Injury            | Work  | rat<br>∢?<br>Yes 2.⊟No       |                                   | scribe how                | injury occur                 | ed                      |   |
| DIVISION   | Attan<br>r deat<br>sctor:<br>by the  | Certification: | 2 Accident investig 3 Suicide 6 Could r 4 Homicide determ  | not be 28e. Plac             | ce of Injury - At I<br>ding, etc. (Speci                   | nome, farm, str<br>ify)          | eet, factory, office  | 163 2                        | 28f. Loca                         | ation (Stre               |                              | er or Rural I           | Route Number,                             |
|            | Hospita<br>4 hours<br>Funeral<br>ely fille   | edical C       | 29a. Certifier 1 Certifyin (Check only one) 1 Medical  | Examiner: On the             | he best of my kn<br>basis of examin<br>inner stated.       | owledge, deat<br>ation and/or in | n occurred at the tim<br>vestigation, in my op                    | e, date and<br>pinion, death | place, and due<br>occurred at the | to the cau                | se(s) and ma<br>e and place, | nner as stat            | ed.<br>he cause(s)                        |
|            | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier  |                              | . 10   | <del></del>                      | 29c License   | number                       | 1                                 | 290                       | d. Date signe                | /                       | ay, Year)                                 |
|            |  |                | Mu G   |                              | MV   | - 02-) (T - :                    | Deien)  | 10                           | T                                 |                           | 12/                          | 12/7                    | 5   |
|            |  |                | 30. Name and address of rsony  | wito complétéd ca            | use of death (Ite  | m ZJa) (Type)                    | - (III)   | A                            | ) [                               | M                         | d                            | (                       | ento.                                     |
| N. A. B.   | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year) DEC 1  | 4 2005                       | Pigistrar's Sign   | ature &                          | berk  | <del>***</del>               | ~ 1 2 11 ~                        | 7-1-1                     | -1 - (                       | 1                       | ,,,,,                                     |

|        |                            |   |                     | State Registrar   | ate of Maryland   |                                 |   | of Healt<br>of Dea                | ath                                  | Re                                 | g. No. UUJ                                   | 42317  |
|--------|----------------------------|---|---------------------|---|---|---------------------------------|---|-----------------------------------|--------------------------------------|------------------------------------|--|--|
| _      |                            | Physici<br>/Medic   | -                   | 1. Decedent's Name (First, Middle, Last)  JULIA A. HARRI                          | SON   | -                               |   |                                   | 2                                    | ECOME                              | er 4, 200                                    | 3. Time of Death 5 11:52AM                         |
|        |                            | Examin  | er                  | a. Facility Name (If not institution, give street                                 | and number)   |                                 | 4b. City, T                                 | own, or Local                     |                                      |                                    | 4c. County of Dea                            |  |
|        |                            | Funeral   | ing (ECT)           | DOCTOR HOSPITAL  5. Social Security Number  6. Sex                                | 7. Age (In yrs. la  |                                 | Il Under                                    | LANHA<br>I Year II Ur<br>Days Hou | nder 24 Hrs. 8                       | B. Date of Birth<br>(Month, Day,   |  | GEORGE S  thplace (State or Foreign ountry)        |
|        |                            | Director  |                     | 579-84-1736 1□ M 3  | <b>X</b> □ 7  | 2 Yrs.                          |   | 54,0                              | 1                                    | PRIL 20                            |  | GEFIELD, S.C.                                      |
| ,      |                            | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Iteme 23e or 28e-f ehow<br>he Medical Examinar must be notified at  | _                   | 10a. State 10b. County  |   | , Town or Lo                    | cation                                      |                                   |                                      |                                    |  | 10d. Inside City Limits                            |
| 7      |                            | ith the Marylar<br>or 28a-f ehow  | ecto                | MD PRINCE GEORG   | E'S LAN   | DOVER                           | 10f. Zip (                                  | Code                              |                                      | 10                                 | 0g. Citizen of What C                        | 1 Ves 2 No   |
| 3      |                            | h with<br>23e or  | by Funeral Director | 706 CARLOUGH ST   |   |                                 | 101. Zip 1                                  | 2078                              | 35                                   |                                    | UNITED ST                                    |  |
| 3      |                            | er deal   | uner                | V Ar  | as Decedent Ever in U.S<br>med Forces?  | 5. 13. V                        | Was Decede<br>Yes, speci                    |                                   | c Origin? (Specr<br>xican, Puerto Ri | fy Yes or No-<br>can, etc.)        | 14. Race - Am<br>Black, Whi                  |  |
| 2      | 036                        | ours aft  | by F                |   | ☐ Yes 2 12 No<br>Yes, Give A<br>ear or Dates:                                     | 1                               | I□Yes 2                                     | No Spe                            | ecify:                               |                                    | Specify: B.                                  | LACK   |
| misen, | 15-0                       | "natur  | Completed           | 15. Decedent's Education (Specify only highest grade com                          |   | (Give                           | lent's Usual<br>kind of world<br>DO NOT use | Occupation done during            | most of working                      | 7                                  | 16b. Kind of Business                        | s/Industry   |
| 3      | 212                        | d withii<br>giene.<br>er than   | omo                 | Elementary/Secondary (0-12) Co  | ollege (1-4or 5+)   |                                 | JO 140 1 US                                 |                                   | OMESTIC                              |                                    | DOMEST1                                      | С  |
| 8      | Maryland 21215-0036        | is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23s or 28s-1 ehov other treumatic event, the Medical Examinar must be notified at | Be                  | 17. Father's Name (First, Middle, Last)   |   |                                 |   | 18. N                             | fother's Name (                      | First, Middle, M                   | Maiden Sumame)                               |  |
| #      | iry<br>is                  | should I  | То                  | JAMES O HARRISON  19a. Informant's Name/Relationship (Type, Pr                    | rint)   | 19b. Mailin                     | g Address                                   |                                   | UTH HOL                              |                                    | City or Town, State,                         | Zip Code)  |
|        |                            | and 2 alth ar n 27 is   |                     | JUANITA T YOUNG/SI  | STER  | 6413                            | 61 s  | t PLA                             |                                      | IVERDÁL                            | •  | 737  |
|        | Baltimore,                 | Pages 1<br>nent of He<br>int: If iter   |                     | 20a. Method of Disposition  1 ♣ Burial 2 ☐ Cremation 3 ☐ Remov                    | 0.0   | ace of Dispo<br>metery, cren    | sition (Nam<br>natory or oti                | e of<br>her place)                | Dat                                  | te 2                               | 20c. Location - City or                      | r Town, State                                      |
|        | altin                      | 글 돈 본 글 .   |                     | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licer see      | ) MD  |                                 |   | METERY<br>Address of F            | 12-8-1<br>acility                    |                                    | LAUREL, M                                    |  |
|        | ñ                          | Depa<br>Impo<br>eny li  |                     | I Mount Joh   | won-k   | lleg 4                          | 25 MA                                       | RYLAND                            | AVE.,                                |                                    |  | TOAKT INC.   |
|        |                            | Pnysician<br>/Medical   | - 77                | resulting in death)   | is that caused the death<br>ise on each line.  PNEUMONIA  Due to (or as a consequ | · ·                             | er the mode                                 | of dying, suc                     | h as cardiac or i                    | respiratory arre                   | est,   | Approximate<br>Interval Between<br>Onset and Death |
|        | 8                          | Examiner  |                     |   | CONGESTIVE  | HEART                           | FAIL  | URE                               |                                      |                                    |  |  |
|        | 160                        | led<br>sit  | Examiner            | if any, leading to immediate cause. Enter Underlying                              | Due to (or as a consequ   |                                 | TOBLO                                       | D.                                |                                      |                                    |  |  |
|        | o,                         | te be executed<br>ysicien and<br>ne burial-transit  |                     | that initiated events c   | CORONARY AR  Due to (or as a consequ  |                                 | LOLAS                                       | L                                 |                                      |                                    |  |  |
|        | 876                        | 9 × 9   | dicai               | d   |   |                                 |   |                                   |                                      |                                    |  |  |
|        | P.O. Box 68760,            | Attending Physician: The law requires that the death certifica ridath. r death. sctor: Atter this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the                     | Physician/Med       | in the past 12 months?  | yes, outcome of pregnar<br> Live birth  | death 3                         | Ectopic pre                                 |                                   |                                      |                                    | 23d. Date of de<br>Month                     | Day Year   |
|        | s, P                       | w requires that<br>s been signed b<br>should be deta  | by PI               | Part II. Dther significant conditions contribut                                   | ing to death but not resu   | lting in the ur                 | nderlying ca                                | use given in P                    | Part I.                              |                                    | acco use contribute t                        |  |
|        | ord                        | requir<br>been si<br>should   | eted                | DEMENTIA  |   |                                 |   |                                   |                                      |                                    |  | robably 4 XUnknown                                 |
|        | Division of Vital Records, | n: The taw<br>icate has<br>r, page 2 a  | Completed           |   |   |                                 |   |                                   |                                      | 1                                  | y prior to<br>ned? death?<br>□ No 1 □ Yes    | utopsy findings available completion of cause of   |
|        | / Vit                      | ysician<br>is certifi<br>director   | To Be               | 25. Was case referred to medical examiner?  1  Yes 2 No Hospita                   | al:<br>1 ☐ Inpatient 2 🖎  | ER/Outpatien                    | t 3 DO                                      | Othor                             | Place of Death (                     |                                    | nce 6 □Other (Spe                            | acifu)   |
|        | n 0                        | ding Physician:<br>h.<br>After this certific<br>funeral director,   |                     | 27. Manner of Death 28:<br>1 XNatural 5 ☐ Pending                                 |   | 28b. Time of<br>Injury          | 28  | tc. Injury at<br>Work?            | 28                                   |                                    | w injury occurred                            | 2017)  |
|        | isio                       | el or Attendir<br>s after death.<br>I Diractor: Af<br>d in by the fu  | ficati              | 2 Accident investigation 3 Suicide 6 Could not be                                 | e. Place of Injury - At hor   | me farm stre                    | M eet factory                               | 1 Tes                             |                                      | 1. Location (Str                   | reet and Number or R                         | Tural Route Number                                 |
|        | Div                        | s after<br>el Dira<br>ed in b   | Certification:      | 4 Homicide determined   | building, etc. (Specify,  | )                               | oot, ladioly,                               | omoo                              |                                      | City or Town,                      | , State)                                     | oral Frosto Ivaliabal,                             |
|        |                            | o the Mospitel or Al<br>hin 24 hours after of<br>T. the Funerel Dirac<br>completely filled in by  | edical              | 29a. Certifier  (Chack only one)  1 Certifying Physician 2 Medical Examiner. Care | : To the best of my know<br>his trie basis of examinati<br>and manner stated.     | vledge, death<br>ion and/or inv | occurred a                                  | t the time, dat<br>in my opinion, | te and place, and death occurred     | d due to the ca<br>at the time, da | use(s) and manner a<br>ite and place, and du | s stated.<br>e to the cause(s)                     |
|        |                            | o the<br>hin 2<br>T the<br>comple   | Мес                 | 29b. Signature and title of certifier   | AH A  | a                               | 29c.  | License numi                      | ber                                  | 29                                 | d. Date signed (Mon                          | th, Day, Year)                                     |
|        | . /                        | 12  |                     | > VY Singh  | HILCOCK.  | 1 10                            | 13  | D 19                              | 897                                  |                                    | 12,5,0                                       |  |
|        |                            | Copp.   |                     | 30. Name an ddress of person willo complet  | ed cause of death Item  | 23a) (Type,                     | Print)<br>OVZ/                              | e P                               | Kwy                                  | GREI                               | EN BEI                                       | T MO   |
|        | 25                         | Sta<br>Registi  |                     | 31. Date liled (Month, Day, Year) DEC 0 9 2005                                    | 32. Registrar's Signat  | иге                             |   |                                   |                                      |                                    |  | 1-17   |

|              |  |                     | 1 - For State Registrer   | State of Marylar  | nd / Depa        |                                     |  | Mental Hy  | giene              | T 1.2219  |
|--------------|--|---------------------|---|---|------------------|-------------------------------------|--|--|--------------------|---|
|              |  | 13                  | Negistrer     Name (First, Middle, Last                                 | 1   |                  | tinoate of                          | Death  | 2. Date of Dea   | Reg. No.           | 3. Time of Death  |
| п            | Physici  | an:                 |   |   | 1                |                                     |  | Month  | Day                | Year 5.30   |
|              | /Medic   |                     |   | s Rudolph Jer   | don              | 45 Ob. T                            |  | Decembe  |                    | 005 A   |
| ř            | Examir   | er                  | 4a. Facility Name (If not institution, give                             |   |                  |                                     | , or Location of Deat                        | n  | 4c. County o       |   |
|              | ·  |                     | St. Mary's Hospi 5. Social Security Number 6. Se                        |   | het histoday)    | Leonar<br>If Under 1 Year           |  | O Date of Birt   |                    | Mary's  |
| * - 5        | Funeral Director   |                     | 1,7   | 7. Age (III y/s.  | 77 Yrs.          | Months Day                          |  | (Month, Day  | v, Year)           | Birthplace (State or Foreign Country)   |
| in           |  |                     | 220-26-4510 Usual Residence of Decedent                                 |   | 11               | l                                   |  | June 28  | , 1928             | Maryland  |
|              | land<br>ow   |                     | 10a. State 10b. County  | 10c. Ci   | ty, Town or Lo   | ocation                             |  |  |                    | 10d. Inside City Limits   |
|              | Mary<br>Heb  | ŏ                   | Maryland St. Mary   | 1.0   | alifor           | nia                                 |  |  |                    | 1 ☐ Yes 2 <b>X X</b> No   |
|              | 28a  | Je C                | Maryland St. Mary  10e. Street and Number                               | 5 0   | allion           | 10f. Zip Code                       | r:   |  | 10g. Citizen of W  | hat Country?  |
|              | With No.   | <u></u>             | 22477 Cornwall Dri  | ***   |                  | 20619                               |  | d distriction of the state of t |                    | ,,  |
|              | feath<br>ms 2  | by Funeral Director | 11. Marital Status  | 12. Was Decedent Ever in U                                | J.S. 13.1        |                                     |  | pecify Yes or No-  | USA<br>14. Race    | - American Indian.  |
| 10           | fler   | Ē                   | 1 Never Married 2 Married   | Armed Forces?<br>1 ☑ Yes 2 ☐ No                           |                  | II Yes, specify Cu                  | f Hispanic Origin? (S<br>ıban, Mexican, Puer | to Rican, etc.)  | Black              | , White, etc.   |
| ဗ္ဗ          | urs a  |                     | 3 X Widowed 4 ☐ Divorced  | 1 ☑ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:          |                  | 1 ☐ Yes 2 🎇 N                       | o Specity:                                   |  | Specify:           | Black   |
| 21215-0036   | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23e or 28e-f ehow<br>he Medical Examiner must be notified at   | Completed           | 15. Decedent's Edu  |   | 16a. Dece        | dent's Usual Occ                    | upation                                      |  | 16b. Kind of Bus   | siness/Industry   |
| 75           | nin 7<br>n n<br>Medi   | ple                 | (Specify only highest grad<br>Elementary/Secondary (0-12)               | College (1-4or 5+)  | life.            | kind of work don<br>DO NOT use reti | e during most of wo<br>red)                  | rking  |                    |   |
| 27           | d with   | E                   | 8   | College (1-401 5+)  | Const            | ruction                             | Worker                                       |  | Home Bui           | llding  |
|              | othe<br>othe   | Bec                 | 17. Father's Name (First, Middle, Last)                                 |   |                  |                                     | 18. Mother's Nar                             | me (First, Middle,   |                    |   |
| <u>a</u>     | ld be<br>lenta<br>kad<br>ic e  | To B                | Thomas William J  | ordon   |                  |                                     | Mary F1                                      | orance H   | ii 1 1             |   |
| Maryland     | shound N   |                     | 19a. Informant's Name/Relationship (T)                                  | ype, Print)   | 19b. Mailir      | ng Address (Stre                    | et and Number or Ru                          |  |                    | itate, Zip Code)  |
|              | nd 2<br>lith a<br>27 to<br>r tra   |                     | Brian Tracy Jerdon  | / Son   | 26004            | Shenandoal                          | n Drive , Me                                 | chanicsvil   | le. Marvla         | and 20659   |
| Baltimore,   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show werly injury or other traumatic event. The Madical Experient must be notified at angle. |                     | 20a. Method of Disposition  | 20b. F  | Place of Dispo   | sition (Name of                     |  | Date   |                    | City or Town, State   |
| 9            | y or   |                     | 1 ☐ Burial 2 ☐ Fremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)      | nemoval nom State   |                  | natory or other p                   |  | cember   | 4.7                |   |
| Ė            | artme<br>ortan<br>injur  |                     | 21. Signature of Funeral Service Licens                                 | 11109   |                  | n Cremato<br>2. Name and Add        | -  | 2005   | Alexandria         | , Virginia  |
| Ba           | Depa<br>Impo<br>eny i  |                     | March Patrin  | A.I.  | _ / Ma           | ttingley-(                          | Gardiner Fun                                 |  |                    |   |
|              |  |                     | 23a. Part1. Enter the disease or comp                                   |   |                  |                                     | ), Leonardto                                 |  |                    | Approximate   |
|              |  |                     | shock, or heart failure. List only o                                    | ne cause on each line.                                    | /                | 1-0                                 | / / D  | - A  | 1631,              | Interval Between<br>Onset and Death   |
| y.           | Physician  |                     | Immediate Cause (Final disease or condition resulting in death)         | a Aut M   | n colore         | lial                                | Jugar  | tim  |                    |   |
|              | /Medical<br>Examiner   |                     | Tosuming in dodain  | Due to (or as a consec                                    | uence of):       |                                     | V  |  |                    |   |
| 20           |  |                     |   | b. ————————————————————————————————————                   |                  |                                     | - V  |  |                    |   |
| 0            | sit ad   | Examiner            | if any, leading to immediate cause. Enter Underlying                    | Due to (or as a consec                                    | querice of):     |                                     |  |  |                    |   |
|              | ecute<br>and<br>tran   | саш                 | Cause (Disease or injury that initiated events resulting in death) Last | c   |                  |                                     |  |  |                    |   |
| 760,         | ate be executed<br>hysician and<br>he burial-transit   | Ω .                 | Todaking in dodkin cast   | Due to (or as a conseq                                    | quence of):      |                                     |  |  |                    |   |
| 876          | ate b<br>hysic<br>the b  | llcal               |   | d   |                  |                                     |  |  |                    |   |
| <b>68</b>    | ing p  | Mec                 | IF FEMALE:  |   |                  |                                     |  |  |                    |   |
| Вох          | th ce  | an/                 | 23b. Was decedent pregnant in the past 12 months?                       | 23c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta |                  | Ectopic pregnan                     | cy   |  |                    | of delivery   |
| 0            | a dea<br>he a  | sici                | 1 ☐ Yes 2 ☐ No  | 4☐ Pregnant at time of o<br>9☐ Unknown                    | death 5          | Other (specify)                     |  |  | Mont               | h Day Year  |
| P.0          | at the   | Physician/Med       | 9 Unknown   |   |                  |                                     |  |  |                    |   |
| Ś            | Attending Physician: The law requires that the death certifica or death.  sclor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.  | þ                   | Part II. Other significant conditions co                                | ntnbuting to death but not res                            | sulting in the u | nderlying cause c                   | nyen in Part I.                              | 23e. Did to  |                    | oute to the cause of death?   |
| Vital Record | w requir<br>been si<br>should  | pel                 | Mullyard De   | mentio, of  | wel              | 1 Mill                              | votes  | 1 🗆 Y  | es 2□No 3          | Probably 4 Dunknown   |
| ပ္ထ          | aw r<br>is be<br>2 sh  | Completed           | Hymentenson   | Perytres  | N/a              | seulo                               | Acsens                                       | 24a. Was a   |                    | ere autopsy findings available  |
| č            | The I  | Eo                  | 10  | 1   |                  |                                     | _  | autop.<br>perfor   | med? de            | ior to completion of cause of ath?  Yes 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ |
| ta           | an:<br>tifica<br>tor, p  | 0                   | 25. Was case referred to medical  |   |                  |                                     | 26 Place of Dea                              | 1 ☐ Yes<br>ath  Check only or  |                    | 1165 21520  |
| >            | ysici<br>s cer<br>direc  | To B                | examiner?   | Hospital:   | ER/Outpatien     | t ax DOA                            | ther   | lome 5 ☐ Resid   |                    | (Specify)   |
| 0            | 9 Ph<br>eral   |                     | 27. Manner of Ceath   | 28a. Date of Injury                                       | 28b. Time of     | -                                   |  |  | ow injury occurred |   |
| Division     | ndin<br>ath.<br>r: Aft<br>e fun  | Certification:      | 1 Natural 5 Pending investigation                                       | (Month, Day Year)   | Injury           |                                     | ☐Yes 2☐No                                    |  |                    |   |
| <u>S</u>     | Atte   | if Ic               | 3 Suicide 6 Could not be determined                                     | 28e. Place of Injury - At h                               | ome, larm, str   | eet, factory, office                | е  |  |                    | or Rural Route Number,  |
| ā            | al or<br>s afte<br>i Dir<br>d in   | ert                 | 4   Nomicide  | building, etc. (Specif                                    | (Y)              |                                     |  | City or Tow  | n, State)          |   |
|              | To the Mospitel or Attending Physicien: The law Within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2  |                     | 29a. Certifier 12 Certifying Phy  | sician: To the best of my kno                             | owledge, death   | occurred at the                     | time, date and place                         | , and due to the c   | ause(s) and man    | ner as stated.  |
|              | P P P  | edical              | (Check only 2 Medical Exemi   | iner: On the basis of examina<br>and manner stated.       | ation and/or inv | vestigation, in my                  | opinion, death occu                          | irred at the time, o   | late and place, ar | d due to the cause(s)   |
|              | To the within 2 To the complet   | Me                  | 29b. Signature and title of certifier                                   |   |                  | 29c. Licer                          | nse number                                   | - 2  | 29d. Date signed   | (Month, Day, Year)  |
|              | ^^   |                     |   |   |                  | A/                                  | 9917   |  | 12/19/             | 65  |
| 10           | NV   |                     | 30 Name and address of person who co                                    | ompleted cause of death (Item                             | n 23a) (Type     | Print)                              | ////   |  | 1 1                |   |
| 19           |  |                     |   |   |                  | •                                   | ia Marria-                                   | 4 20610  |                    |   |
| 10           | Sta  | te i                | 31. Date liled (Month, Day, Year)                                       | ildewood Shopping 32 egistrar's Signa                     |                  | , odlilori                          | ira, maryian                                 | u 20019  |                    |   |
|              | Registr  | _                   | DEC 2 0 20  | 05  | & A              | ede                                 |  |  |                    |   |

DHMH 17 Rev 1/2001

Registrar

|   |                | State of Maryland / Dep  1 - State Registrer Ce  | artment of Health and M<br>rtificate of Death   |   | ene 05  | 42320   |
|---|----------------|--|---|---|---|---|
| Physicia  |                | 1. Decedent's Name (First, Middle, Last)  ISAIAH R. JOHNSON  |   | 2. Date of Death<br>Month<br>DECEMBER                     | Day Year  | 3. Time of Death 6:49 P                         |
| /Medic<br>Examin  | **             | 4a. Facility Name (If not institution, give street and number)  LAUREL REGIONAL HOSPITAL   | 4b. City, Town, or Location of Death  LAUREL  | DHOLLIDE  | 4c. County of Death                               | h   |
| Funeral<br>Director   |                | 5. Social Security Number 6. Sex 1 $\boxtimes$ M 2 $\square$ F 52 Yrs. Usual Residence of Decedent   | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day,<br>JUNE 24               |   | hplace (State or Foreig<br>untry)<br>INGTON, DC |
| death with the Maryland<br>ms 23e or 28e-f show<br>rmust be notified at   | Director       | 10a. State         10b. County         10c. City, Town or L           MD         PRINCE GEORGE'S         LAUREL           10e. Street and Number         10e. Street and Number  | 10f. Zip Code   | 10  | g. Citizen of What Co                             | 10d. Inside City Limits 1 ∑ Yes 2 ☐ No untry?   |
| ours after death with<br>el', or Items 23e or<br>Examine must be  | by Funeral [   | 8104 GORMAN AVENUE # 220  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:   | 20707  Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2⊠ No Specify: | ecify Yes or No-<br>Rican, etc.)                          | U.S.A.  14. Race - Americal Black, White Specify: |   |
| 2 ho  | Completed t    | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)   | dent's Usual Occupation kind of work done during most of work DO NOT use retired) LTL HANDLER             | ing 1   | 6b. Kind of Business/I                            | Industry  |
| d Mental Hyg<br>narked othe<br>natic evant,   | To Be C        | 17. Father's Name (First, Middle, Last) ISAIAH JOHNSON   | LELIA   | MAE RUSS  | SELL  | En Control                                      |
| permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "rany injury or other traumatic evant, It a Magance. |                | STACY JOHNSON/WIFE 8108  20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State   | matory or other place)  | LAUREL, N   | IARYLAND Oc. Location - City or                   | 20707<br>Town, State                            |
| permit. P<br>Departme<br>Importan<br>any injur  |                | 21. Signature of Funeral Service Licensee  | 2. Name and Address of Facility J. 474 LANDOVER ROAD  | B. JENKI<br>LANDOVER                                      | ,MARYLAND   | L HOME  |
| Cate be executed /Medical Examiner /Medical Examiner : the prival-transit   | dical Examiner | 23a. Part1. Enter the disease of complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  CONGESTIVE HEART  Due to (or as a consequence of):  HYPERTENSION  Due to (or as a consequence of):  c.  Due to (or as a consequence of): |   |   |   | Approximate Interval Between Onset and Death    |
| eath certifi<br>attending  <br>for use as   | Physician/Med  |  | □Ectopic pregnancy<br>□ Other (specify)   |   | 23d. Date of deli<br>Month                        | very<br>Day Year                                |
| w requires that<br>been signed by<br>should be deta   | by             | Part II. Other significant conditions contributing to death but not resulting in the u   | inderlying cause given in Part I.   |   | acco use contribute to                            |   |
|   | Completed      |  |   | 24a. Was an<br>autopsy<br>perform<br>1 Yes 2              | prior to c  | topsy findings available ompletion of cause of  |
| ng Phys<br>fter this<br>meral di  | atlon: To Be   | 25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation  28a. Date of Injury (Month, Day Year)  | nt 3 DOA Cther: 4 Nursing Ho  | h (Check only one)<br>me 5 ☐ Residen<br>28d. Describe hov | ce 6 Other (Spec                                  | ify)  |
| To tha Hospital or Attandi<br>within 24 hours efter death.<br>To tha Funarel Diractor: A<br>completely filled in by the fu  | Certification: | 3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)   |   | City or Town,   |   |   |
| To tha Hospital within 24 hours e To tha Funarel Completely filled  | Medical        | 29a. Certifier     (Check only one)  1    Certifying Physician: To the best of my knowledge, deal (Check only one)  1    Medical Examiner: On the basis of examination and/or in and manner stated.  |   | ed at the time, dat                                       |   | to the cause(s)                                 |
| (15)  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type,  | D23181  |   |   | 13, 2005  |
| Sta   | te             | R.G. BHOJRAJ M.D. 704 GORMAN AVENU   | E # 7 LAUREL, MARY  | LAND 207  | 07  |   |
| Registra  |                | DEC 1 6 2005   | 4   |   |   |   |

|                   |  |                 | 1 - For<br>State<br>Registrar  | State of N   | Marylan                         |                                 | artmen<br>tificate         |                          |                              |                           | R                             | eg. No.                 | 005  | 42321  |
|-------------------|--|-----------------|--|--|---------------------------------|---------------------------------|----------------------------|--------------------------|------------------------------|---------------------------|-------------------------------|-------------------------|--|--|
| Г                 | Physici  | an              | Decedent's Name (First, Middle, La   |  |                                 |                                 |                            |                          |                              |                           | Date of Dea<br>Month          | Day                     | Year   | 3. Time of Death                                   |
|                   | /Medic   | _               | Betty J. James   |  |                                 |                                 |                            |                          | l                            |                           | Decemb                        | _                       | 2, 2005  | 5:15 A M   |
| *                 | Examin   | er              | 4a. Facility Name (If not institution, gir<br>Heritage Harbour   |  |                                 |                                 | Anna                       |                          | Location o                   | r Death                   |                               |                         | ounty of Death   | obol   |
|                   | Funoval  |                 |  |  | Age (In yrs. I                  | last birthday)                  | If Under                   | 1 Year                   | If Under 2                   |                           | . Date of Birth               | 1                       |  | place (State or Foreign                            |
|                   | Funeral Director   |                 | 469-28-9774  | 1□M 2∏ F   | 76                              | Yrs.                            | Months                     | Days                     | Hours                        | Min.                      | (Month, Day                   | 1,19                    | 29 Minn  | esota  |
|                   | P .  |                 | Usual Residence of Decedent  |  | 1.0 00                          |                                 |                            |                          |                              |                           |                               |                         |  |  |
|                   | anylar<br>ehow   | _               | 10a. State 10b. County   |  |                                 | y, Town or Lo                   |                            |                          |                              |                           |                               |                         |  | 0d. Inside City Limits 1 ☐ Yes 2X No               |
|                   | Ne M   | ecto            | Maryland Queen   | Anne's   | Sto                             | evensv                          |                            | 0-4-                     |                              |                           |                               | 10- Oiti-               | - (11111 0   |  |
|                   | with t   | ä               |  | 7mt  | 210                             |                                 | 10f. Zip                   |                          |                              |                           |                               |                         | en of What Coul  | ntry ?   |
|                   | death with the Maryland<br>rms 23a or 28e-f ehow<br>r.must be notified at  | Funeral Directo | 200 Terrapin Gr  | ove Apt  |                                 | S. 13. V                        |                            | 1666                     |                              | in? (Speci                |                               | USA<br>14               | I. Race - Amend  | can Indian.  |
|                   | fer d  | 표               | 1 ☐ Never Married 2 ☐ Married  | Armed Force  | s?                              | :                               |                            |                          |                              | Puerto Ri                 | fy Yes or No-<br>can, etc.)   |                         | Black, White,  | etc.   |
| g                 | et', o   | ρ               | 3  Widowed 4 □ Divorced  | If Yes, Give<br>Year or Date                             | s:                              | •                               | 1 ☐ Yes 2                  | <b>⊘</b> Mo              | Specify:                     |                           |                               | 5                       | Specify: Whi   | te   |
| 5-0036            | be filed within 72 hours after death with the Marylan ital Hyglene. Id other then "naturet, or items 23s or 28s-f show event, the Madical Examinet must be notified at | Completed       | 15. Decedent's E<br>(Specify only highest gr   | ducation<br>ade completed)                               |                                 | 16a. Deced                      | dent's Usua<br>kind of wor | al Occupa                | ition<br>turing most         | of working                |                               |                         | of Business/In   | *  |
| 2                 | within<br>ene.<br>then "   | mpi             | Elementary/Secondary (0-12)  | College (1-4d  | or 5+)                          | life. I                         | DO NOT us                  | e retired)               | lu <i>ring</i> most<br>)     |                           |                               | Truc                    | king/Tr  | ansportation                                       |
| 21                | filed v<br>Hygie<br>other t  | ဒ               | 12 17. Father's Name (First, Middle, Las   | *1   |                                 | Pers                            | onnel                      | Ass                      | istan                        |                           | First, Middle,                | Maiden S                | (umame)  |  |
| auc               |  | ) Be            | Emil G. Anders   |  |                                 |                                 |                            |                          |                              | orenc                     |                               | Maiden 5                | Westl  | und  |
| Maryland          | should<br>nd Men<br>marke<br>imaric  | ဥ               | 19a. Informant's Name/Relationship   |  |                                 | 19b. Mailir                     | na Address                 | (Street a                |                              |                           |                               | r. City or              | Town, State, Zip   |  |
|                   | s 1 end 2 should<br>f Health and Mer<br>Item 27 is marke<br>other traumatic  |                 | Thomas DiCato -  | Son-in-La  | aw.                             | 308                             | Green                      | Mou                      | ntain                        | Ct                        | Pasde                         | na l                    | MD 2112  | 2  |
| ē,                | S 1 e  |                 | 20a. Method of Disposition   |  | 20b. P                          | lace of Dispo<br>emetery, cren  |                            |                          |                              | Dat                       |                               |                         | ation - City or To   |  |
| Ë                 | Pages<br>nent of<br>ent: if it<br>ury or o   |                 | 1 ☐ Burial 2 ☐ Cremation 3 { 4 ☐ Donation 5 ☐ Other (Special   | ⊒Removal from Sta<br>fy)                                 | KO                              | as Crei                         |                            |                          | i i                          | /13/2                     | 2005                          | Edge                    | water. 1   | Maryland   |
| altimore,         | 그문문문   |                 | 21. Signatury Funeral Service Lice   | osee   |                                 | 22                              | . Name an                  | d Addres                 | s of Facility                | /                         |                               | 1270                    |  |  |
| m                 | Departiment important  |                 | Mornto all   | l-   |                                 | 2                               | <del>9</del> 9398          | olom                     | Kalas<br>ons I               | sland                     | rad. Ho                       | me<br>dgewa             | P.A.<br>ater, M  | 21037  |
| ,                 | Physician<br>/Medical<br>Examiner  |                 | 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)                   | a. One to for  | sed the death line.             | n. Do not ent                   | er the noo                 | e of dying               | eq. Luch as                  | cardiac or r              | respiratory at r              | est,                    | leck   | Approximate<br>Interval Between<br>Onset and Death |
| 8760,             | The law requires that the death certificate be executed to has been signed by the ettending physicien and tage 2 should be detached for use as the burial-transit      | dical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to for  | 42                              | uence of):  Lyfe                | NS/                        | 101                      |                              |                           |                               |                         |  |  |
| P.O. Box 6        | at the death certific<br>by the ettending p  | Physician/Me    | IF FEMALE: 23b. Was decedent pregnant in the past 2 months? 1 □ Yes 2 □ No 9 □ Unknown   |  | 1 2 ☐ Fetal<br>t at time of de  | I death 3                       | Ectopic pr<br>Other (sp    |                          |                              |                           |                               | 23                      | id. Date of delive<br>Month                                | ory<br>Day Year                                    |
|                   | w requires that<br>been signed b<br>should be deta   | by              | Part II. Other significant conditions  | contributing to deati                                    | h but not resu                  | ulting in the u                 | nderlying c                | ause give                | en in Part I.                |                           | 23e: Oid to                   | ^                       |  | ne cause of death?<br>ably 4 □Unknown              |
| Il Records,       |  | Completed       |  |  |                                 |                                 |                            |                          |                              |                           | 24a. Was a autop perior       | sy -                    | 24b. Were auto<br>prior to co<br>death?<br>1 \(\sum \) Yes | psy findings available mpletion of cause of        |
| VII S             | icien: Th<br>certificete<br>rector, pag  | Be              | 25. Was case referred to medical examiner?   | Hoepital   |                                 |                                 |                            | Otho                     |                              |                           | Check only of                 |                         |  |  |
| o                 | Physi<br>this<br>al dir  | Ţ               | 1 ☐ Yes 2 No<br>27. Manner of ceath  | Hospital: 1 🗀 Inpa                                       |                                 | ER/Outpatien<br>28b. Time of    |                            |                          | 4 22 140                     | 7.                        | d. Describe h                 |                         | Other (Specif  | y)   |
| 5                 | After<br>funer   | ion             | 1 Vatural 5 Pending  | 28a. Date of I<br>(Month,                                | Day Year)                       | Injury                          | M                          | 8c. Injury<br>Work       | res 2 □ l                    |                           | d. Describe ii                | ow injury               | occurred   |  |
| Division of Vital | To the Hospitel or Attending Physicien: within 24 hours effer deeth. To the Funerel Director: After this certificacompletely illed in by the funeral director.         | Certification:  | Accident investigation  3 Suicide 5 Could not 1  4 Homicide determined   | 28e. Place of  | Injury - At ho<br>etc. (Specify | ome, farm, str                  |                            |                          |                              |                           | f. Location (S<br>City or Tow |                         | Number or Rura   | d Route Number,                                    |
|                   | To the Hospitel within 24 hours e To the Funerel I completely filled   | edicai          | 29a. Certifier 1₩ Certifying P (Check only one) 2 Medical Exa  | hysician: To the be<br>miner: On the basis<br>and mahrer | of examina                      | wledge, death<br>tion and/or in | n occurred<br>vestigation  | at the tim<br>, in my op | ne, date and<br>pinion, deal | d place, an<br>h occurred | d due to the o                | ause(s) a<br>late and p | nd manner as s<br>place, and due to                        | tated. the cause(s)                                |
|                   | To the within To the comple  | W               | 29b. Signature and title of contifier  | Hote   | DM                              | UD.                             | 296                        | License                  | 2 8                          | 68                        | 3                             | 29d. Date               | signed (Month,   | Day Year)  |
|                   |  | 0               | 30. Name and add ss of person  |  | of leath (Item                  | W. Ilni                         | Print)<br>Verci            | tv P                     | STvd.                        | #326                      | Silve                         | r Sn                    | ring, M  | 20901  |
|                   |  |                 | Richard Osei Ak  | oto, M.D.  | strar's Signa                   | ture                            |                            |                          |                              | ., 520                    |                               |                         |  | 20001  |
|                   | Sta<br>Registi   |                 | DEC 1 A  | 2005   | Giologia o                      | K                               | brass                      | 81                       |                              |                           |                               |                         |  |  |

|                            |   |                   | 1 - For<br>State<br>Registrar  | State of Maryland  |                                  | artment of<br>rtificate of            |   | i Mental Hy                                | giene 05                                  | 42322                                  |
|----------------------------|---|-------------------|--|--|----------------------------------|---------------------------------------|---|--|---|--|
| 4                          |   | 39                | 1. Decedent's Name (First, Middle, Last)   |  |                                  |                                       |   | 2. Date of De<br>Month                     |   | 3. Time of Death                       |
|                            | Physici<br>/Medio   |                   | Marian   | Gentz Joh  | nson                             |                                       |   | Decemb                                     |   |  |
|                            | Examir  |                   | 4a. Facility Name (If not institution, give st   | reet and number)   |                                  | 4b. City, Town,                       | or Location of De                       | ath  | 4c. County of                             | Death                                  |
|                            |   |                   | 415 Russell Avenue   |  |                                  | Gaith                                 | nersburg                                | re   0 D-1 -/ D:                           |   | gomery                                 |
| 1                          | Funeral   |                   | 5. Social Security Number 6. Sex   | 7. Age (In yrs. II   | Vec                              | Months Day                            |   | n. (Month, Da                              | ay, Year)                                 | Birthplace (State or Foreign Country)  |
|                            | Director  |                   | 709-03-6481 Usual Residence of Decedent  | 91   | L                                |                                       |   | April 2                                    | 2, 1914                                   | Illinois                               |
|                            | a-f ehow  | ctor              | 10a. State 10b. County   | 10c. City  | , Town or Lo                     | ocation                               |   |  |   | 10d. Inside City Limits                |
|                            |   |                   | Maryland Montgome  | ry Ga  | aither                           | sburg                                 |   |  |   | 1X Yes 2 □ No                          |
|                            | ith th  | Directo           | 10e. Street and Number   |  |                                  | 10f. Zip Code                         |   |  | 10g. Citizen of Wha                       | at Country?                            |
|                            | ath w   | rai               | 415 Russell Avenue   | · · · · · · · · · · · · · · · · · · ·                        |                                  |                                       | 877                                     |  | USA                                       |  |
|                            | er de   | Funeral           | The Mariner Creates  | <ol><li>Was Decedent Ever in U.:<br/>Armed Forces?</li></ol> | S. 13.                           | Was Decedent of<br>If Yes, specify Cu | f Hispanic Origin?<br>Jban, Mexican, Pu | (Specify Yes or No<br>erto Rican, etc.)    | 14. Race -<br>Black,                      | American Indian,<br>White, etc.        |
| 36                         | rs aft  | by F              | 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:                   |                                  | 1 ☐ Yes 2 🖾 N                         | o Specify:                              |  | Specify:                                  | TTI * .                                |
| 21215-0036                 | tura<br>stura   | edi               | 15. Decedent's Educ  |  | 16a. Dece                        | dent's Usual Occ                      | upation                                 |  | 16b. Kind of Busin                        | White ness/Industry                    |
|                            | n n n n n n n n n n n n n n n n n n n   | Completed         | (Specify only highest grade Elementary/Secondary (0-12)  | completed) College (1-4or 5+)                                | (Give<br>life.                   | kind of work don<br>DO NOT use reti   | e during most of v<br>red)              | vorking                                    |   | •                                      |
|                            | d with  |                   | Liententary/Secondary (0-12)   | 4  | Но                               | omemaker                              |   |  | Home                                      |  |
| פר                         | al Hyg  | BeC               | 17. Father's Name (First, Middle, Last)  |  |                                  |                                       | 18. Mother's N                          | lame (First, Middle                        | , Maiden Sumame)                          |  |
| Baltimore, Maryland        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show amportant: If item 27 is marked other than "natural", or itema 23a or 28a-f show amportant: Item Maryland Evantinat must be notified at another.  Description of the property of the Maryland Evantinat must be notified at another.   | 0                 | Otto A.  | Gentz  |                                  |                                       |   | Bertha                                     | a Pauls                                   | son                                    |
| lar                        |   |                   | 19a. Informant's Name/Relationship (Typ  |  |                                  |                                       |   |  | er, City or Town, Sta                     |  |
| 2                          |   |                   | Marcia Haller/Daug   |  |                                  |                                       | Place, M                                | iontgomer                                  |   | , MD. 20886                            |
| Ore                        | Ses 1   |                   | 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Re   | moval from State   | emetery, crei                    | sition (Name of<br>matory or other p  |   |  | 20c. Location - Cit                       | ty or Town, State                      |
| ij                         | t. Pa<br>tmen<br>tant:  |                   | 4 □Donation 5 □ Other (Specify)  |  | ropoli                           | tan Crem                              | natory 12                               | 2/14/05                                    | Alexandr                                  | ia, Virginia                           |
| Bai                        | Department |                   | 21. Signature of Funeral Service Licensee \  |  |                                  |                                       |   |  |   |  |
|                            |   |                   | 208.77 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate |  |                                  |                                       |   |  |   |  |
| 100                        | The law requires that the death certificate be executed to the law requires that the has been signed by the attending physician and large 2 should be detached for use as the buriat-transit  | Jer               | shock, or heart failure. List only one<br>Immediate Cause (Final   | e cause on each line.  |                                  |                                       | ,g, 000 20 02                           | ias of roophatory a                        |   | Interval Between<br>Onset and Death    |
|                            |   |                   | disease or condition resulting in death)   | Congestive I   |                                  | Failure                               |   |  |   | 3 days                                 |
|                            |   |                   | Sequentially list conditions  b. Diastolic Dysfunction   |  |                                  |                                       |   |  |   |  |
|                            |   |                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | Due to (or as a consequ                                      | Due to (or as a consequence of): |                                       |   |  |   |  |
|                            |   | Examine           | Cause (Disease or injury that initiated events   | Hypertension   | a                                |                                       |   |  |   |  |
| o,                         |   | Ex                | resulting in death) Last Due to (or as a consequence of):  |  |                                  |                                       |   |  |   |  |
| 8760,                      |   | Physician/Medical |  |  |                                  |                                       |   |  |   |  |
| 9                          | eath certific<br>attending pl<br>for use as t   | Mec               | IF FEMALE:   |  |                                  |                                       |   |  |   |  |
| Вох                        | ath c   | lan/              | 23b. Was decedent pregnant in the past 12 months?  | c. If yes, outcome of pregnai<br>1☐Live birth 2☐Fetal        | death 3[                         | Ectopic pregnar                       | псу                                     |  | 23d. Date of Month                        |  |
| Ö                          | the a   | ysic              | 1 ☐ Yes 2 🛣 No<br>9 ☐ Unknown  | 4□Pregnant at time of de<br>9□Unknown                        | eath 5                           | Other (specify)                       |   |  |   | ,                                      |
| cords, P.O.                | that the de<br>ted by the a<br>detached t   | P                 | Part II. Other significant conditions cont   | ributing to death but not resu                               | ılting in the u                  | nderlying cause o                     | given in Part I.                        | 23e. Did                                   | tobacco use contribu                      | ite to the cause of death?             |
|                            | ires tha<br>signed<br>d be de   | d by              | Chronic Atrial Fibrillation 1 □ Yes 2 ☒ No 3 □ Probably 4 □ Unknown  |  |                                  |                                       |   |  |   |  |
|                            | w require<br>been si<br>should b  | lete              |  |  |                                  |                                       |   |  | an 24h Wei                                | b. Were autopsy findings available     |
| Re                         | he lav<br>e has   | Completed         |  |  | LSease                           |                                       |   | - auto                                     | psy prio<br>prmed? dea                    | r to completion of cause of<br>th?     |
| Division of Vital Records, | ificate<br>or, pa   | e C               | Macular Degeneration 25. Was case referred to medical  | on   |                                  |                                       | 26. Place of F                          | 1 ☐ Yes<br>Death (Check only               |   | Yes 2□ No                              |
|                            | Physician:<br>r this certifica<br>ral director, i   | 0 3               | examiner?  | ospital:   | ER/Outpatier                     | at 3D DOA                             | )thor                                   |  | idence 6 Other                            | (Specify)                              |
|                            | g Phy<br>er thi   | n: T              |  |  |                                  |                                       |   |  | oposity)                                  |  |
|                            | i or Attending Physician: The after death.  Director: After this certificate hit in by the funeral director, page   | atio              | 1 XNatural 5 ☐ Pending<br>2 ☐ Accident investigation   | (Midral, Day 1601)   | M 1 Yes 2 No                     |                                       |   |  |   |  |
| Vis                        | r Atte  | Certification:    |  |  |                                  |                                       |   |  |   | or Rural Route Number,                 |
|                            | ital or<br>irs afte<br>ral Dir<br>led in  | Cer               |  |  |                                  |                                       |   |  |   |  |
|                            | Hospital<br>24 hours 2<br>Funeral<br>tely filled  | edical            | (Check only 2 Medical Examination  | cian: To the best of my knower: On the basis of examinat     | wledge, deat<br>ion and/or in    | h occurred at the vestigation, in my  | time, date and pla<br>opinion, death oc | ice, and due to the<br>curred at the time, | cause(s) and manne<br>date and place, and | er as stated.<br>I due to the cause(s) |
|                            | the<br>off  | Med               | one)  29b. Signature and title of certifier  | and manner stated.   | -                                |                                       |   |  |   |  |
| •                          | To To Con   | _                 | 29b. Signature and title of certifier  29c. License number  29d. (   |  |                                  |                                       |   | _  | . Date signed (Month, Dey, Year)          |  |
| 7                          |   |                   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |  |                                  |                                       |   |  |   | 14, 2005                               |
|                            |   |                   | H. Robert Birschbac  |  | 1                                | · ·                                   | o Caith                                 | archura                                    | Marvland                                  | 20877                                  |
|                            | Sta   | te                | 31. Date filed (Month, Day, Year)  | Registrar's Signal   |                                  | TT Avenu                              | e, Galln                                | erspurg,                                   | тагутана                                  | 20011                                  |
|                            | Regist  |                   | NFC 1 5 2009   | Marie &  | 16/2009                          | 1982                                  |   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 16b, 22 For FD, TCHD, 12/20/05, sbb Certificate of Death Regino 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year MABEL ELIZABETH MILLER JACKSON 12/19/2005  $1015_{D}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON
If Under 1 Year If Under 24 Hrs. 120 PORT STREET TALBOT 2520 3aT 265 TITLA 10 15 TO 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09/17/1912 Funeral Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 2 🕏 F <del>223-43-7920</del> 93 Yrs. Director VA Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hydient flen "natural", or Items 23a or 28a-f show 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 ie marked other then "natural", or Items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at Director MD 1 Yes 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 120 PORT STREET 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Speci BLACK þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry TEACHER Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If item 27 le marked other the any injury or other treumatic EDUCATION TRACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ William Ashby Miller Queen Elizabeth Taylor(Miller) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Moonyene Jackson-Amis(daughter) 120 Port Street Easton, MD 21601 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Oaklawn Mausoleum & Staunton, 4 ☐ Donation 5 ☐ Other (Specify) LENK Memory Garden tauton, 21. Signature of Funeral Spr 22. Name and Address of Facility Service Eric Dashiell Funeral Home , EAston, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Thyroup /Medical Due to (or as a consequence of) **Examiner** Pulmenay Doet & Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 4 Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performed 2 No 1∐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 🗆 Nursing Home ٩ 2 ER/Outpatient 3 DOA 5 esidence 6 □Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification; After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funerel C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Zya. Certifier (Check only one)

State Registrar

29b. Signature and title of certifier

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene [] [] 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Vear /Medical Olivia 04:35a<sup>M</sup> Bonnie 8. 2005 Burgoyne Johnson December 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockvi11e

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Montgomery Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2√□ F Director 220-38-4337 61 May 12, 1944 Maryland | Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 27 is marked other than "natural, or Items 23e or 28e-1 show traumatic event, the Medical Exameter must be notified at 10d. Inside City Limits 1 ☐ Yes 2√□ No Director AZMaricopa Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 2050 West Dunlap Avenue C89 85021 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 25tNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 72 in and Mental Hygiene. 7 is marked other than "ne Elementary/Secondary (0-12) College (1-4or 5+) Massage Therapist Self Employed 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Verne Wilson ဥ Olivia Gustafson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 of Health Item 27 Leroy W. Johnson -Husband 2050 West Dunlap Ave. C89 Phoenix, AZ 85021 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Pages Depertment of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Adams-Green Fundame 4 □ Donation 5 □ Other (Specify) 12/9/2005 Herndon, VA 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Adams-Green Funeral Home Chin 721 Elden St. Herndon, VA 20170 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat Physician METASTATIC CERVICAL CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No P.O. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS pi CC 1 ☐ Yes 2 ☑ No ٩ this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 8, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles M. Harrison, MD 1355 Piccard Dr., Rockville, MD 31. Date filed (Month, Day, Year) 32\_Registrar's Signature State Registrar DEC 3 0 2005

|                 |   |  | 1 - State Ce<br>Registrer Ce  | artment of Health and Menta<br>rtificate of Death  | Reg. NO.   |
|-----------------|---|--|---|--|--|
|                 | Physici<br>/Medio   |  | 1. Decedent's Name <i>(First, Middl</i> e, <i>Last)</i> MARION JACKSON  | Mo   | e of Death nth Day Year Cember 8,2005 12:46 PM   |
| Ì.              | Examir  |  | 4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital   | 4b. City, Town, or Location of Death Clinton   | 4c. County of Death Prince George  |
|                 | Funeral<br>Director   |  | 5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1241-68-5925  7. Age (In yrs. last birthday)  Yrs.  | If Under 1 Year   If Under 24 Hrs.   8. Date   Months   Days   Hours   Min.   April                  | e of Birth<br>nth, Day Year) 11 27,1946 9. Birthplace (State or Foreign<br>Country) North Carolina |
|                 | iryland<br>ihow   | _  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  MD 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2  |  | 10d. Inside City Limits  |
|                 | vith the Ma<br>or 28a-f   | Director   | MD Prince George Marlow Ho  10e. Street and Number  4001 Bedford Way  | 10f. Zip Code  | 1 ☐ Yes 2 ☐ No   |
| 336             | be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural" or iteme 23e or 28e-f show event, Ite Medical Examines trust be notified at | by Funerai   |   | Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, €         | us or No- s or No- Black, White, etc.  Specify: Black  |
| 51215-0036      | d within 72 hou<br>piene.<br>r then "nature<br>the Medical E  | Completed  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5  Cleri   | ident's Usual Occupation skind of work done during most of working DO NOT use retired)               | 16b. Kind of Business/Industry  U.S. Government  |
| Maryland 21     | d ta b  | To Be C  | 17. Father's Name (First, Middle, Last) Sylvester Jackson   | Lillie Mae A   | Middle, Maiden Sumame)<br>Artis  |
|                 | is 1 and 2 should of Health and Men item 27 is marke other traumatic  |  |   | ng Address <i>(Street and Number or Rural Route</i><br>Bedford Way Marlow H                          |  |
| gaitimore,      |   |  | 20a. Method of Disposition 20b. Place of Disp   |  | 20c. Location - City or Town, State  |
| Bait            | permit. Page<br>Depertment of<br>Important: If<br>eny injury or<br>once.  |  | 21. Signature of Funeral Service Lies see   | ill Funeral Home,Inc.<br>and, MD 20746   |  |
|                 | Physician   | atory arrest, Approximate Interval Between Onset and Death |   |  |  |
| o0,             | Examiner be executed by by sician and the punal-transit in the punal-transit.   | i Examiner   | Due to (or as a consequence of):  | ARDIAL INFARCTIO<br>BLOOD LOSS   |  |
| P.O. BOX 68/6U, | ath certifi<br>attending<br>for use as  | Physician/Medical  |   | □Ectopic pregnancy<br>□ Other (specify)  | 23d. Date of delivery  Month Day Year  |
|                 | w requires that the de<br>been signed by the s<br>should be detached  | þ  | Part II. Dther significant conditions contributing to death but not resulting in the CARCINOMA OF THE PENIS   | inderlying cause given in Part I. 236  | e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown             |
| vital Records,  | The tay<br>ate has<br>page 2  | Completed  |   | 10   | a. Was an autopsy prior to completion of cause of death?  Yes 2 No 1 Yes 2 No                      |
|                 | Physician:<br>this certific<br>ral director,  | To Be  | 25. Was case referred to medical examiner?  1 □ Yes 2 □ No  Hospital: 1 □ Inpatient 2 □ ER/Outpatie   | 26. Place of Death (Check  | confy one)  ☐ Residence 6 ☐ Other (Specify)  |
| 0               | g Phys<br>er this<br>eral dii   | Ä.   | 27. Manner of Death 28a. Date of Injury 28b. Time of  |  | scribe how injury occurred   |
| UNISION         | To the Kospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral                                       | Certification:   | 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)                      | M 1 ☐ Yes 2 ☐ No reet, factory, office 28f. Loca   | ation (Street and Number or Rural Route Number,<br>r or Town, State)                               |
| _               | e Hospital or Attendi<br>124 hours after death<br>16 Funerel Director: A  | ledical Ce   | 29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal 2 Medical Exeminer: On the basis of examination and/or in and manner stated. | h occurred at the lime, date and place, and due<br>vestigation, in my opinion, death occurred at the | to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s)             |
|                 | To the within 2 To the complet  | Me   | 29b. Signature and title of certifier   | 29c. License number D 40324  | 29d. Date signed (Month, Day, Year) DECEMBER 9, 2005   |
| _               | (5)   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, TERRY JODKIE, M.D. 7503 SURA  | ATTS ROAD, CLINTON   | , MARYLAND 20735   |
|                 | Sta   | te   | 31. Date filed (Month, Day, Year)  32 Registrar's Signature   | - e :  |  |

|  |  |                | For<br>State<br>Registrar  | State of I                                | Maryland / De                                     | partment<br>ertificate                                     |                             |                                  |                                     | giene 05                           | 42326                                 |
|--|--|----------------|--|---|---|--|-----------------------------|----------------------------------|-------------------------------------|------------------------------------|---------------------------------------|
|  | Dhysisi  |                | 1. Decedent's Name (First, Middle, L   | ast)                                      |   |  |                             |                                  | 2. Date of De.<br>Month             | ath<br>Day Ye                      | 3. Time of Death                      |
|  | Physici<br>/Medic  |                | Helen Johnson  |   |   |  |                             |                                  | Decembe                             | 1                                  |                                       |
|  | Examin   | ier            | 4a. Facility Name (If not institution, g   |   | er)   | 4b. City, T  | own, or Lo                  | ocation of Deat                  | h                                   | 4c. County of D                    |                                       |
|  |  |                | 9330 Dubarry A   |   | A da to addition                                  |  | Lanha                       | m<br>f Under 24 Hrs              | 0.000                               |                                    | George's                              |
|  | Funeral Director   |                | 5. Social Security Number 6. 577–36–2135   | Sex 7.<br>1 □ M 2020 F                    | Age (In yrs. last birtho                          | Months   |                             | Hours Min.                       |                                     | y, Year)                           | Birthplace (State or Foreign Country) |
| 1  |  |                | Usual Residence of Decedent  |   | 70  |  |                             |                                  | Aug. 10                             | , 1929 51                          | elltown, MD                           |
|  | yland  |                | 10a. State 10b. County   |   | 10c. City, Town o                                 | Location   |                             |                                  |                                     |                                    | 10d. Inside City Limits               |
|  | a-fsl  | ctor           | Maryland Prince  | e George':                                | s Lanl  | nam  |                             |                                  |                                     |                                    | 1 TyYes 2 □ No                        |
|  | or 28  | Director       | 10e. Street and Number   |   |   | 10f. Zip   | Code                        |                                  |                                     | 10g. Citizen of What               | Country?                              |
|  | 23a  | ai             | 9330 Dubarry A   |   |   |  | 0706                        |                                  |                                     | USA                                |                                       |
|  | r dea  | Funerai        | 11. Marital Status   | 12. Was Decede<br>Armed Force             | es?   | <ol> <li>Was Deceded</li> <li>If Yes, specified</li> </ol> | ent of Hispa<br>fy Cuban, I | anic Origin? (S<br>Mexican, Puer | pecify Yes or No<br>to Rican, etc.) | - 14. Race - A<br>Black, W         | merican Indian,<br>/hite, etc.        |
| 36   | s afte   | by Fi          | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced                             | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Date | _   | 1 ☐ Yes 2  | □ <u>X</u> No 5             | Specify:                         |                                     | Specify:                           | White                                 |
| 8  | I within 72 hours after death with the Maryland<br>liene.<br>r than "natural", or Items 23a or 28a-f show<br>tha Madical Examinat must be notified at              | ed b           | 15. Decedent's   |   |   | cedent's Usual   | Occupatio                   | on.                              |                                     | 16b. Kind of Busine                | ess/Industry                          |
| 5  | in 72<br>n "na   | piet           | (Specify only highest g  | rade completed)                           | (C  | ive kind of work<br>e. DO NOT use                          | k done duri                 | ing most of wo                   | rking                               | TOD. TAING OF EGOING               | and the death                         |
| 212  | within<br>piene.<br>r than "   | Completed      | Elementary/Secondary (0-12)  | College (1-4                              | or 5+)  | Homer  | maker                       | •                                |                                     | Pvt.                               |                                       |
| b  | be filed<br>stal Hygic<br>od other   | BeC            | 17. Father's Name (First, Middle, Las  | •   |   |  | 18                          |                                  |                                     | Maiden Sumame)                     |                                       |
| <u>la</u>  |  | 2              | Thomas William   | n Lusk                                    |   |  |                             | Rebec                            | cca Emma                            | Bell                               |                                       |
| , Maryland 21215-0036  | 12<br>12<br>13   |                | 19a. Informant's Name/Relationship Thomas Johnson                                  |   |   |  |                             |                                  | nham, MD                            | er, City or Town, Stat<br>20706    | e, Zip Code)                          |
| Baltimore,   | 0 0 = =  |                | 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec |   | 10   916  | sposition (Name<br>crematory or oth<br>ill Ceme            | her place)                  | 12–1                             | 7-05                                | Laurel,                            |                                       |
| Balti  | permit. Pag<br>Department<br>Important: I<br>any injury o  |                | 21. Signature of Funeral Service Lic   | of Facility Be                            | eall Fund<br>Bowie, I                             | eral Home<br>ND 20715                                      |                             |                                  |                                     |                                    |                                       |
|  |  |                | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List on           | mplications that cau                      | sed the death. Do not                             | enter the mode   | of dying, s                 | such as cardia                   | or respiratory a                    | rrest,                             | Approximate<br>Interval Between       |
|  | Physician  | П              | Immediate Cause (Final disease or condition  |   | bral Infar  | ction  |                             |                                  |                                     |                                    | Onset and Death 6 days                |
|  | /Medical   |                | resulting in death)  | Due to (or                                | as a consequence of)                              |  |                             |                                  |                                     |                                    | _                                     |
| 10   | Examiner   | L              | Sequentially list conditions,  | bCerel                                    | bral Artor  | cclus  | sion                        |                                  |                                     |                                    | 6 days                                |
|  | pe is  | ine            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury      |   | as a consequence of)                              |  | ,                           |                                  |                                     |                                    |                                       |
| _  | and<br>and<br>I-tran   | Examine        | that initiated events<br>resulting in death) Last                                  |   | oral Arter:                                       |  | OSIS                        |                                  |                                     |                                    | 6 yrs.                                |
| 8760,  | cate be executed<br>physician and<br>the burial-transit  |                |  |   |   |  |                             |                                  |                                     |                                    | 1                                     |
| 687  | ficate<br>physics the  | edicai         |  | d   |   |  |                             |                                  |                                     |                                    |                                       |
| Box  | eath certific<br>attending p   | n/M            | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outco                        | me of pregnancy                                   | 3 □Ectopic pre   | ~~~~~                       |                                  |                                     | 23d. Date of                       | delivery                              |
| 0  | The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Me   | in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown                                   |   | it at time of death                               | 5 Other (spe   |                             |                                  |                                     | Month                              | Day Year                              |
| S,   | es tha<br>igned<br>be det  | by P           | Part II. Other significant conditions  | contributing to deat                      | th but not resulting in th                        | e underlying ca  | use given i                 | in Part I.                       | 23e. Did to                         | obacco use contribute              | e to the cause of death?              |
| ord  | w requir<br>been si<br>should I  |                | Type 1 Dia   | cetes Mel                                 | litus   |  | -                           |                                  | 1 🗆 🗎                               | /es 2 □ No 3 □                     | Probably 4 Dunknown                   |
| Type 1 Diabetes Mellitus  Type 1 Diabetes Mellitus  Type 2 Diabetes Mellitus  Type 2 Diabetes Mellitus  25. Was case referred to medical examiner?  Hospital: Hospital: 1 Diabetes 2 DEB/Outpatient 3 DEA Other: 4 Diabetes Mellitus |  |                |  |   |   |  |                             |                                  |                                     | rmed? prior death                  |                                       |
| of Vital   |  | 0              | 25. Was case referred to medical   |   |   |  | 21                          | 6. Place of Dea                  | 1 ☐ Yes<br>ath (Check only o        |                                    | /es 2□ No                             |
| Ξ  | > 20 0   | To B           | examiner?<br>1 ☐ Yes 2 ☐ <b>X</b> No   | Hospital: 1   Inp                         | atient 2 ER/Outpa                                 | itient 3 DO  | Other                       |                                  |                                     | dence 6 Other (5                   | Specify)                              |
|  | ding Ph<br>h.<br>After th<br>funeral   |                | 27. Manner of Death  1 Natural 5 Pending   | 28a. Date of (Month,                      | Injury 28b. Tim<br>Day Year) Inju                 | e of 28  | Bc. Injury at<br>Work?      | t                                | 28d. Describe I                     | now injury occurred                |                                       |
| Si<br>O  | Attending in death. ector: After by the fune   | atic           | 2 Accident investigat  | on  |   | М  | 1 🗆 Yes                     | s 2 No                           |                                     |                                    |                                       |
| Division   | l or Attendate deatl Director:   | Certification: | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine                                | d 289. Place of                           | Injury - At home, farm<br>, etc. <i>(Specify)</i> | , street, factory,   | office                      |                                  | 28f. Location (8<br>City or Tox     | Street and Number or<br>vn, State) | Rural Route Number,                   |
|  | Hospital<br>24 hours a<br>Funeral E  |                | 29a. Certifier 1 Certifying  | Physician: To the h                       | est of my knowledge, o                            | eath occurred a  | at the time                 | date and place                   | and due to the                      | cause(s) and manner                | ac etated                             |
|  |  | Medicai        | (Check only 2 Medical Ex   | aminer: On the basi<br>and manner         | is of examination and/o                           | r investigation,   | in my opini                 | ion, death occu                  | urred at the time,                  | date and place, and o              | due to the cause(s)                   |
|  | To the within To the comple  | 2              | 29b. Signature and title of certifier  | 0   |   | 29c.   | License n                   | umber                            |                                     | 29d. Date signed (M                |                                       |
| <u> </u>   |  |                | AM   | C. Nes                                    | · M   | 7  | 1161                        | 177                              |                                     | 19-1                               | -05                                   |
| R  | (8)  |                | 30. Name and address of person wh  | ·   |   |  | T 1                         | *                                | 20765                               |                                    |                                       |
|  | C CH   | ate.           | Andres C. La:  | La 9326 .                                 | Lanham Seve                                       | ETII KO.   | Lanna                       | am, MD                           | 20706                               |                                    |                                       |
| State 31. Date filed (Month, Day, Year) Registrar  DEC 1 2 2005  |  |                |  |   |   |  |                             |                                  |                                     |                                    |                                       |

|                     |   |                  | 1 - For State Registrar  | State of Maryland /   | Depa                       |  | alth and M                | lental Hy  | _                         | ns.                   | 12327  |
|---------------------|---|------------------|--|---|----------------------------|--|---------------------------|--|---------------------------|-----------------------|--|
|                     | Physici   |                  | Decedent's Name (First, Middle, Last)     Amanda   | Johnso  |                            |  |                           | 2. Date of Dea<br>Month<br>Nov.                    | th<br>Day                 | Year<br>2005          | 3. Time of Death 4:42 P M  |
|                     | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give  | street and number)  |                            | 4b. City, Town, or L   |                           |  |                           | ty of Death           |  |
|                     |   |                  | Southern Maryland 5. Social Security Number 6. Sec   |   | hirthday)                  | Clinton If Under 1 Year  | If Under 24 Hrs.          | 8. Date of Birt                                    | Princ                     |                       |  |
|                     | Funeral<br>Director   |                  |  | M 2135F 88  | Yrs.                       |  | Hours Min.                | (Month, Da)<br>Feb. 3                              | /, Year)                  | Wash                  | place (State or Foreigr<br>intry)<br>ington, DC                    |
|                     | and<br>and  |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, To   | wn or Lo                   | cation   |                           |  |                           |                       | 10d. Inside City Limits  |
|                     | a-fsho  | tor              | MD Prince Ge   | eorges Lar  | idove                      | er   |                           |  |                           |                       | 1 X Yes 2 No   |
|                     | or 28   | Funeral Director | 10e. Street and Number   |   |                            | 10f. Zip Code  |                           |  | 10g. Citizen o            |                       | intry?   |
|                     | eath v  | erai             | 7627 Barlowe Rd.   | 12. Was Decedent Ever in U.S.   | 13. \                      |  | 785<br>panic Origin? (Spi | ecify Yes or No-                                   |                           | SA<br>ace - Ameri     | ican Indian,   |
| 020                 | hin 72 hours after death with the Maryland<br>e.<br>m. "natural", or items 23a or 28a-f show<br>Medical Exama ser must be notified at                             | þ                | 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced   | Armed Forces?  1  Yes 2  No If Yes, Give Year or Dates:                                     |                            | Was Decedent of Hisp<br>f Yes, specify Cuban,<br>1 □ Yes 2⊠ No       |                           | Rican, etc.)                                       | Spec                      | ack, White            |  |
| Maryland 21215-0036 | na "na  | Completed        | 15. Decedent's Edu<br>(Specify only highest grad   | cation 16 e completed)  College (1-4or 5+)  | a. Deced<br>(Give<br>life. | dent's Usual Occupati<br>kind of work done du<br>DO NOT use retired) | on<br>ring most of work   | ing  | 16b. Kind of              | Business/Ir           | ndustry  |
| 717                 | M E E   | Com              | Elementary/Secondary (0-12)  | 2 yrs.  | Secr                       | etary  |                           |  | DMV                       |                       |  |
|                     | 0 0 0   | Be               | 17. Father's Name (First, Middle, Last)  |   |                            | 1  | 8. Mother's Name          |  |                           | ame)                  |  |
| Z                   | 2 should be<br>and Mental<br>is marked c  | ဥ                | William Cooper  19a. Informant's Name/Relationship (Ty   | rpe, Print)   | 9b. Mailir                 | ng Address (Street an  | Margare  d Number or Rura |  |                           | n, State, Zi          | p Code)  |
| N N                 | 1 and 2 s<br>Health ar<br>tam 27 is<br>other trau   |                  | Warren Johnson/Son   | ·   |                            | Barlowe R  |                           | dover,   |                           |                       |  |
| <u> </u>            | iges 1 and<br>of Healt<br>if itam 2<br>or other   |                  | 20a. Method of Disposition 1 △Burial 2 □ Cremation 3 □ F   | como  | of Dispo<br>tery, crer     | sition (Name of matory or other place)                               |                           | Date   | 20c. Location             | - City or T           | own, State   |
| Ĕ                   | Pa<br>ant<br>ury  |                  | * 4 □ Donation 5 □ Other (Specify)   | Harm  |                            | Memorial   |                           | -2005  | Lando                     | ver,                  | 4D•  |
| g<br>n              | permit. Departr importa any inji  |                  | 21. Signature of Funeral Service Licens  | shall   |                            | larshaff s<br>1217 9th S   |                           |  |                           | nc 20                 | 011  |
|                     | nysician<br>/Medical<br>Examiner  |                  | 23a. Part. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, | such as cardiac o   | or respiratory ar          | rest,  |                           | Approximate<br>Interval Between<br>Onset and Death |                           |                       |  |
|                     | ted<br>nsit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury that initiated events   | Due to (or as a consequence Pleural Effus   |                            |  |                           |  |                           |                       |  |
| Ď                   | a execu<br>an and<br>rial-tra   |                  | that initiated events<br>resulting in death) Last  | Due to (or as a consequence   |                            |  |                           |  |                           |                       |  |
| <b>68/6</b> 0,      | cate be<br>ohysici<br>the bu  | dicai            |  | Anemia  |                            |  |                           |  |                           |                       |  |
| O. Box 6            | The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  | 23c. If yes, outcome of pregnancy 1   |                            | Ectopic pregnancy Other (specify)                                    |                           |  |                           | ate of deliv          | rery<br>Day Year   |
| rds, P              | quires that<br>in signed b  | by               | Part II. Other significant conditions con  | ntributing to death but not resulting   | g in the u                 | nderlying cause given  | in Part I.                | *  | bacco use co<br>es 2. 本No |                       | the cause of death?<br>bably 4 □Unknown                            |
|                     |   | Completed        |  |   |                            |  |                           | 24a. Was autop perfor                              | med?                      | prior to co<br>death? | opsy findings available ompletion of cause of 2 \( \text{No} \) No |
| Vital               | Physician: Th<br>this certificate<br>ral director, pag  | Be               | 25. Was case referred to medical examiner?   | Hospital:   |                            | Other  | 26. Place of Deatl        |  |                           |                       |  |
| Ö                   | Phys<br>r this<br>ral dia   | tlon: To         | 1 Yes 2 No   | 1 Hinpatient 2 EHV  | Outpatier  Time of Injury  | 28c. Injury a<br>Work?   | 4   Indising no           | me 5 🗌 Resid<br>28d. Describe h                    |                           |                       | fy)  |
| DIVISION            | To the Hospital or Attending within 24 hours after death.  To tha Funeral Diractor: After completely filled in by the fune  | Certification:   | 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of Injury - At home,<br>building, etc. (Specity)                                 | farm, str                  | eet, factory, office   |                           | 28f. Location (S<br>City or Ton                    |                           | ber or Run            | al Route Number,   |
|                     | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in   | edical (         |  | sician: To the best of my knowled<br>ner: On the basis of examination<br>and manner stated. |                            |  |                           |  |                           |                       |  |
|                     | To the within 24  | Me               | 29b. Signature and title of certifier  | (m m)   |                            | 29c. License r   | number                    | 1  | 29d. Date sign            | ed (Month,            | Day, Year)   |
| ,                   | 7   |                  |  |   |                            | D141   | 56                        |  | Nov.                      | 28, 2                 | 2005   |
| R                   | (4)   |                  | 30. Name and address of person who co  |   |                            | _  | Larca                     | MT   |                           |                       |  |
|                     | Sta   | ate              | Ciro A Montanez  31. Date filed (Month, Day, Year)   | 32 Registrar's Signature  |                            |  | Largo                     | , MD.  |                           |                       |  |
|                     | Regist  |                  | DEC 1 3 2005   | Below &   | Los                        | elle)  |                           |  |                           |                       |  |

|                |  | 1                   | State Registrar   2-15-05 Amend#5.Pe   | te of Maryland / Dep<br>rFam.PGC cr <i>Ce</i>   | artment of Hea<br>ertificate of De                                   |  |  | ene 005                                   | 42328  |
|----------------|--|---------------------|--|---|--|--|--|---|--|
|                | Physicia   |                     | Decedent's Name (First, Middle, Last)  | ohnson  |  |  | 2. Date of Death                               | 8 <sup>Day</sup> 2005                     | 3. Time of Death                                       |
|                | /Medic   | al -                | Morris Bernard Jo  |   | 4b. City, Town, or Loc   | cation of Death                                    | 12 0   | 4c. County of Dea                         |  |
|                | Examin   | er '                | Prince George's Hospi  |   | Cheverly   |  |  | P.G.                                      |  |
|                | , Funeral<br>Director  |                     | 5 Social Security Number 6. Sex 140 1 M 2[   | 7. Age (In yrs. last birthday 46 Yrs.   |  | Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth<br>(Month, Day, Y<br>10/25/19 | 9. Bi<br>059 Wa                           | thplace (State or Foreign ountry) shington, DC         |
|                | and  | -                   | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or I  | ocation  |  |  |   | 10d. Inside City Limits                                |
|                | Maryi  | to                  | MD PG  | Branywi   | ne   |  |  |   | 1 ☐Yes 2 ☐ No  |
|                | h the  | irec                | 10e. Street and Number   |   | 10f. Zip Code  |  | 100  | g. Citizen of What C                      | ountry?  |
|                | 23a c  | la l                | 8135 Grayden Lane  |   | 20613  | . 0 : 0 /0   | -14 - 14 - 1 - 1 - 1                           | U.S.A                                     | organ Indian   |
| 30             | be filed within 72 hours after death with the Maryland tat Hygiene. d other than "natural", or items 23a or 28e-f show event, the Medical Examiling notal by notified at | by Funeral Director | 1 Never Married 27 Married 1 If Y  | s Decedent Ever in U.S.<br>ned Forces?<br>IYes 2 E No<br>es, Give X<br>ar or Dates:           | . Was Decedent of Hispa<br>If Yes, specify Cuban, N<br>1 Yes 2 XIO S | anic Origin? (Spe<br>Mexican, Puerto F<br>Specify: | cry Yes or No-<br>Rican, etc.)                 | Black, Wh                                 |  |
| 212-003p       | 2 hou  | ted                 | 15. Decedent's Education<br>(Specify only highest grade comp   |   | edent's Usual Occupation<br>e kind of work done during               | n<br>na most of workir                             | 10   | 6b. Kind of Busines                       | s/Industry   |
| 7              | ithin 7<br>ne.   | Completed           | Elementary/Secondary (0-12) Col  | liege (1-4or 5+)  | DO NOT use retired)  |  |  |   |  |
| 2              | filed w<br>Hygier<br>other th  | S                   | 12th  17. Father's Name (First, Middle, Last)  | Cor   | rectional O  |  | (First, Middle, Ma                             | D.C. GOV6 aiden Sumame)                   | ernment  |
| and            | ed ita   | To Be               | Morris Chestnut  |   |  | Regina   | Watson   |   |  |
| Maryland       | should be<br>and Menta<br>marked<br>umatic ev  | -                   | 19a. Informant's Name/Relationship (Type, Pri  |   | iling Address (Street and  |  |  |   | Zip Code)  |
|                | and 2<br>ealth a<br>m 27 le  |                     | Jannease J. Johnson  |   | Grayden La   |  |  | MD 20613  Oc. Location - City of          | r Town State   |
| ore<br>e       | Pages 1<br>nent of Hi<br>int: If Itan  |                     | 20a. Method of Disposition  1XXBurial 2 □ Cremation 3 □ Remova   | II Irom State   | position (Name of rematory or other place)                           | 1  |  | •   |  |
| Baltimore,     |  |                     | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee,                                     |   | Mem. Park 22. Name and Address o                                     |  |  | Landover,                                 | Maryland   |
| Ba             | permit. Depertr Imports any inj  |                     | · Soudon sho   | ( univo   | P.O. 90x 416;  | FIG  |  | al Services<br>20752                      |  |
| الله<br>د الحد |  |                     | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause                 | s that caused the death. Do not e   | nter the mode of dying, s  | such as cardiac o                                  | r respiratory arres                            | st,                                       | Approximate<br>Interval Between<br>Onset and Death     |
| 4              | Physician  |                     | Immediate Cause (Final disease or condition  | Congestive Hea  |  |  |  |   | 1 year   |
| . 951          | /Medical<br>Examiner   |                     | resulting in death)  | Due to (or as a consequence of):  Hypertension  |  |  |  |   | 1 year   |
| A 1            |  | er                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury | Due to (or as a consequence of):  |  |  |  |   | i year   |
|                | cuted  | Examiner            | that initiated events c  |   |  | -  |  |   |  |
| 760,           | ate be executed<br>hysicien and<br>the burial-transit  | EX                  | resulting in death) Last   | Oue to (or as a consequence of):  |  |  |  |   |  |
| $\infty$       | physic<br>physic<br>the b  | dical               | d  |   |  |  |  |   |  |
| .O. Box 6      | The law requires thet the death certificate be executed are has been signed by the attending physicien and page 2 should be detached for use as the burial-transit       | Physician/Med       | in the past 12 months?   |   | B Ectopic pregnancy Dother (specify)                                 |  |  | 23d. Date of d<br>Month                   | elivery<br>Day Year                                    |
| ٠ <u>.</u>     | s thet t<br>ned by<br>e deta   | ьу Рһ               | Part II. Other significant conditions contributi   |   | underlying cause given i   | in Part I.   | 23e. Did toba                                  | acco use contribute                       | to the cause of death?                                 |
| rds            | w require<br>been sig<br>should b  | ed t                | Sepsis Recurren  | it  |  |  | 1 🗆 Yes  | s 2 <b>½</b> No 3□                        | Probably 4 Unknown                                     |
| Records, P.    | e faw re<br>has be<br>je 2 sh  | Completed           |  |   |  |  | 24a. Was an<br>autopsy<br>perform              | 24b. Were prior to death                  | autopsy findings available<br>o completion of cause of |
| <u>س</u>       |  |                     |  |   |  |  | 1 ☐ Yes 2                                      | No 1□Y                                    | es 2 No  |
| Vital          | Physician: Th<br>r this certificate<br>ral director, pag   | ) Be                | 25. Was case reterred to medical examiner?  1 ☐ Yes 2 ☑ No Hospita   | al:<br>1 ☐ Inpatient 2 ☑ ER/Outpat  | Other  |  | n <i>(Check only one</i>                       | o)<br>nce 6                               | necify)  |
| ō              | g Physer this eral di  | n; To               | 27. Manner of Death 28a  | a. Date of Injury (Month, Day Year)  28b. Time Injury   | of 28c. Injury at  |  | 28d. Describe hor                              |   | osiy)  |
| ion            | Attending<br>r death.<br>ector: Afte<br>by the fune  | atlo                | 1 Natural 5 Pending 2 Accident investigation   | (Moshin, Day Tour)  |  | s 2 No   |  |   |  |
| Division of    | or Attendate death Director:   | Certification;      | 3 Suicide 6 Could not be determined 286  | <ul> <li>Place of Injury - At home, farm,<br/>building, etc. (Specify)</li> </ul>             | street, factory, office  |  | 28f. Location (Str<br>City or Town,            |   | Rural Route Number,                                    |
|                | To the Hospitel or Attending Physician: within 24 hours after death. To the Funaral Director: After this certific completely filled in by the funeral director,          | edical Ce           | (Check only 2 Medical Examiner: 0  | : To the best of my knowledge, de<br>on the basis of examination and/or<br>and manner stated. | eath occurred at the time,<br>investigation, in my opini             | , date and place,<br>nion, death occurr            | and due to the ca<br>ed at the time, da        | use(s) and manner<br>ite and place, and d | as stated.<br>ue to the cause(s)                       |
| <b>)</b>       | To the<br>within<br>To the   | Me                  | 29b. Signature and title of certifier  | my his  | 29c License n  | 2 <del>7</del> 3                                   | MD. 29   | od. Date signed (Mo                       | nth, Day Fear)   |
| 2              | (1)  |                     | 30. Name and address of person who complet   | ed cause of death (Item 23a) (Type  | oe, Print)   |  |  | ,   |  |
|                |  |                     | Revathy Murphy, M.D.   |   | Road, Lando  | over, Ma   | ryland   |   |  |
|                | St<br>Regist   | ate                 | 31. Date filed (Month, Day, Year) <b>9EC 1 4 2005</b>  | 2. Registrar's Signature  | and the  |  |  |   |  |
| 4              | , regist   | 1                   | DEC 1 4 2001   | The second  |  |  |  |   |  |

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Bown & Sparke

2005

|                                |   |                     | 1 - State State Registrar   | of Maryland   |                                    | artmen<br>tificate   |                         |                                       | and Me                   | -  | iene                      | 005  | 423                               | 30                 |
|--------------------------------|---|---------------------|---|---|------------------------------------|--|-------------------------|---------------------------------------|--------------------------|--|---------------------------|--|-----------------------------------|--------------------|
|                                | Physici   | an                  | Decedent's Name (First, Middle, Last)   |   |                                    |  |                         |                                       |                          | 2. Date of Dea<br>Month                      |                           | _ Year_  | 3. Time of                        | Death              |
|                                | /Medic  |                     |   | S LUTHER I  | KEENE                              |  |                         |                                       |                          | Decembe                                      |                           |  | 7:00                              | Ам                 |
|                                | Examin  | er<br>—             | 4a. Facility Name (If not institution, give street and r<br>14801 Motter Station Ro                   | ad  |                                    | Roc  | ky R                    | Location o                            |                          |  |                           | nty of Death<br>derick                                 |                                   |                    |
|                                | Funeral<br>Director   |                     | 5. Social Security Number 218-24-1660 6. Sex 1 ★ M 2 □ F  | 7. Age (In yrs. las   | t birthday)<br>Yrs.                | If Under<br>Months   | 1 Year<br>Days          | If Under 2<br>Hours                   |                          | 8. Date of Birth<br>(Month Day<br>May 26,    | <sup>Y</sup> 1928         | 9. Birth<br>Mary                                       | place (State of<br>Intry)<br>Land | r Foreign          |
|                                | and w   |                     | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, 7  | Town or Lo                         | cation   |                         |                                       |                          |  |                           |  | 10d. Inside Ci                    | ity Limits         |
|                                | Mary<br>-f sho  | tor                 | Maryland Frederick  | Rocky   | y.Rid                              | ge   |                         |                                       |                          |  |                           |  | 1 □ Yes                           | ,                  |
|                                | h the   | irec                | 10e. Street and Number  |   |                                    | 10f. Zip   | Code                    |                                       |                          | 1  | 0g. Citízen               | of What Cou  | intry?                            |                    |
|                                | 23a c   | ralD                | 14801 Motter Station, R   | oad   |                                    | 21   | 778                     |                                       |                          |  | U.S                       | .A.  |                                   |                    |
| 036                            | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic avant, the Medical Examinar must be notified to | by Funeral Director | 1 Never Married 2 Married 12 Ye   | ecedent Ever in U.S.<br>Forces?<br>s 2 No<br>Give<br>Dates: Korea           |                                    | Vas Deced<br>Yes, spec   |                         | spanic Orig<br>n, Mexican<br>Specify: | gin? (Spec<br>, Puerto R | cify Yes or No-<br>lican, etc.)              |                           | Race - Ameri<br>Black, White,<br>acify: Wh             |                                   |                    |
| 2-0                            | 72 ho   | eted                | 15. Decedent's Education (Specify only highest grade complete)  | d)  | 16a. Deced                         | ent's Usua   | l Occupa                | tion                                  | of workin                | G.   | 16b. Kind o               | f Business/In  | ndustry                           |                    |
| 2                              | vithin ne.  | Completed           | Elementary/Secondary (0-12) College   | (1-4or 5+)  |                                    | kind of wor<br>OO NOT us   |                         | unig most                             | OI WOIKIII               | 9  | т.                        | 11 01  | -                                 |                    |
| 15<br>D                        | e filed within<br>al Hygiene.<br>I other than '   |                     | 17. Father's Name (First, Middle, Last)   |   |                                    | Carpe  |                         | 18 Mother                             | r's Name                 | (First, Middle, M                            |                           |  | x, Inc                            |                    |
| ylan                           | should be<br>nd Mental<br>marked o  | To Be               | Harvey Luther Keeney  |   |                                    |  |                         | Lana                                  | Mar                      | guerite                                      | Ho1t                      |  |                                   |                    |
| Mar                            | and 2 sho<br>salth and<br>n 27 is m   |                     | 19a. Informant's Name/Relationship (Type, Print) Emma L. Keeney (Wife)                                | 1   | <sup>19b. Mailin</sup><br>14801    | g Address<br>Mott  | (Street a               | <sup>nd Numbe</sup><br>tatio          | n or Rural               | Route Number<br>ad, Roc                      | ky Ri                     | wn, State, Zi <sub>l</sub><br>dge, M                   | Code)<br>ID 2177                  | 8                  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and<br>Department of Health<br>Important: If Itam 27<br>any injury or other tr<br>once.   |                     | 20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐ Removal fro  4 ☐ Donation 5 ☐ Other (Specify) |   | e of Dispos<br>etery, crem<br>Hope |  |                         |                                       | .2/15                    | 41   |                           | on - City or To  | own, State<br>Iarylan             | d                  |
| Balti                          | permit. Pa<br>Departmen<br>Important:<br>any injury<br>once.  |                     | 21. Signature of Fulleye/ Service Liversee  | Purt  | RÖ                                 | BERT <sup>and</sup>  | E <sup>Address</sup>    | ATTEY                                 | & S                      | ON FUNE                                      | RAL H                     | OMES,  | P.A.                              |                    |
|                                |   | -                   | 23a. Part1. Enter the disease, c<br>shock, or heart failure. Likt only one cause o                    | sed th eath.  |                                    |  |                         |                                       |                          | THURM  |                           | MD 217   | Approximate                       | <b>3</b>           |
| H                              | Pnysician<br>/Medical   |                     | Immediate Cause (Final disease or condition resulting in death)                                       | Moca  | idi                                | d  | In                      | force                                 | tes                      | ~  |                           |  | Interval Bett<br>Onset and D      |                    |
| 8760,                          | Examine be executed bhysician and burial-transit site burial-transit  | dical Examiner      | cause. Enter Underlying Cause (Cis association) that initiated events c.                              | o (or as a consequent   | nce X                              | aut  | er                      | 0                                     | 0                        | seort  | 7                         |  | 15 y                              | lass               |
| .O. Box 6                      | The law requires that the death certifics ate has been signed by the attending pt cage 2 should be detached for use as to   | Physician/Med       | in the past 12 months?  | outcome of pregnancy<br>birth 2 Fetal de<br>gnant at time of death<br>known | ath 3 🗌                            | Ectopic pre<br>Other (spe  |                         |                                       |                          |  |                           | Date of delive   | •                                 | 'ear               |
| ₾.                             | w requires that been signed bestoned  | by                  | Part II. Other significant conditions contributing to   | death but not resulting   | ng in the un                       | derlying ca  | use giver               | n in Part I.                          |                          | 23e. Did tob                                 | 1-/                       |  | he cause of department            | eath?<br>nknown    |
| Records,                       |   | Completed           | . 00  |   |                                    |  |                         |                                       |                          | 24a. Was ar<br>autopsy<br>perform<br>1 Yes 2 | /                         | b. Were auto<br>prior to co<br>death?<br>1 \( \sum Yes | psy findings a mpletion of ca     | vailable<br>use of |
| Vita                           | cian:<br>ertific<br>ector,  | Be                  | 25. Was case referred to medical examiner?  |   |                                    |  | -,                      | 26. Place                             | of Death (               | Check only one                               |                           |  |                                   |                    |
| )<br>                          | Physic<br>this or   | <u>۵</u>            | 1 ☐ Yes 2 No Hospital: 1 [  |   | /Outpatient                        |  | _                       | 4   IAUI                              |                          | e 5 Reside                                   |                           |  | y)                                |                    |
| uc.                            | ding Phy<br>h.<br>After thi<br>funeral o  | ion                 | . ,   | e of Injury 28<br>onth, Day Year)   | b. Time of<br>Injury               | M 28   | Bc. Injury :<br>Work?   | at<br>P<br>es 2 ∐ N                   | 6                        | ld. Scribe ho                                | w injury occ              | urred  |                                   |                    |
| Division of                    | Attanding Physician:<br>er death.<br>rector: After this certifici<br>by the funeral director, i   | ficat               | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pla                                 | ce of Injury - At home  | , farm, stre                       |  |                         | 82 5 14                               |                          | f. Location (Str                             | eet and Nu                | mber or Rura   | l Route Numb                      | oer.               |
| 2                              |   | Certification:      | 4   Homicide buil   | ding, etc. (Specify)  |                                    |  |                         |                                       |                          | City or Town                                 | State)                    |  |                                   | 0.,                |
|                                |   | Medical             | 29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the and ma     | he best of my knowle<br>basis of examination<br>pager stated.               | dge, death<br>and/or inv           | occurred a<br>estigation,  | t the time<br>in my opi | , date and<br>nion, death             | place, an                | d due to the ca<br>I at the time, da         | use(s) and<br>te and plac | manner as st<br>e, and due to                          | ated.<br>the cause(s)             |                    |
|                                | To the within 2 To the complet  | ×                   | 29b. Signature and title of certifier   | Pa II.  | 001                                | 29c.   | License                 | number                                | 205                      | 29   | 12/13                     | ned (Month,  | Day, Year)                        |                    |
| 12                             | 2+1   |                     | 30. Name and address of person who completed ca   | 0 - 0   |                                    | Print)   | 5                       | /1 1                                  |                          | 0:0  | 110                       | 227  |                                   |                    |
|                                | Sta<br>Registra   |                     | 31. Date filed (Month, Day, Year) 32.  DEC 1 4 2005   | Redistrar's Signature   | 3                                  | DT.  |                         | natsk                                 | oure.                    | 17/  | VI                        | 12 (   |                                   |                    |
|                                | 3.00  |                     | I I L003  |   | r 16                               | A STATE OF THE PARTY OF THE PAR |                         |                                       |                          |  |                           |  |                                   |                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 2005 DECEMBER **Physician** HELEN KING 6:30 A M WRIGHT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MANOR CARE NURSING HOME SILVER SPRING MONTGOMERY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) MARCH 3 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1 M 2 X F 84 Yrs. Director WASHINGTON, DC 579-12-1523 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20910 2501 MUSGROVE ROAD U.S.A. 'natural', or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: þ Specify 3 

Widowed 4 

Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12th HOUSE WIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS CHARLES F. WRIGHT KATIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6249 SOUTHERN MARYLAND BLVD LOTHIAN, MARYLAND 20711 SHARON KING/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial \_2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) FT. LINCOLN 12/15/05 BRENTWOOD, MARYLAND 21. Signature of Funeral Pervice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ALZHEIMERS DEMENTIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** HYPERTENSION Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Yes 28 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 21 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21710 2003 Call 30. Name and address 4 production who completed cause of death (Item 23a) (Type, Print) 1011 N. CAPITAL STREET N.E. WASHINGTON, DC 20002 EDSEL GAXONO M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State 16 Registrar DHMH 17 Rev 1/2001

|                     |   |                  |   | State of Maryla   |  |                                   |   |                                   | -                                 |                    | _                                      |  |
|---------------------|---|------------------|---|---|--|-----------------------------------|---|-----------------------------------|-----------------------------------|--------------------|--|--|
|                     |   | •                | 1 - For<br>State<br>Registrar   |   |  |                                   | of Death                                  |                                   |                                   | Reg. No            | 2005                                   | 42332  |
|                     | Dhusiai   | 3                | 1. Decedent's Name (First, Middle, Last)  |   |  |                                   |   |                                   | 2. Date of De.<br>Month           | ath<br>Da          | y Year                                 | 3. Time of Death                                 |
|                     | Physici:<br>/Medic  |                  | Evelyne D. Keene  |   |  | I                                 |   |                                   | Decembe                           |                    | 2, 2005                                | 2:56 A <sup>M</sup>                              |
| 1                   | Examin  | er               | 4a. Facility Name (If not institution, give   |   |  | _                                 | own, or Location                          | of Death                          |                                   |                    | . County of Death                      |  |
|                     | Funeral   |                  | Laurel Regional Ho 5. Social Security Number 6. Sec   |   | rs. last birthday)   | Laure                             | Year If Under                             |                                   | 8. Date of Birt<br>(Month, Da     |                    | ince Geo                               | place (State or Foreign intry)                   |
| . ***<br>           | Director  |                  | 130-14-6633   | ]M 2 <b>∑</b> F   | 82 Yrs.  | Months                            | Days Hours                                | Min.                              | May 31                            |                    |  | York   |
|                     | and w   |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c.  | City, Town or Lo   | ocation                           |   |                                   |                                   |                    |  | 10d. Inside City Limits                          |
|                     | Maryla<br>feder   | ō                |   |   | •  |                                   |   |                                   |                                   |                    |  | 1 ☐ Yes 2X No                                    |
|                     | r 28a-  | Director         | Maryland   Montgomer  10e. Street and Number  | у 51  | lver Sp  | 10f. Zip C                        | ode                                       |                                   |                                   | 10g. Cit           | tizen of What Cou                      | intry?   |
|                     | within 72 hours after death with the Maryland<br>ene.<br>than "naturel", or iteme 23s or 28s-f show<br>he Madical Examinar must be notified at  |                  | 3124 Gracefield Ro  | ad #KC322   |  | 2090                              | 4   |                                   |                                   | USA                |  |  |
|                     | r dea   | Funeral          | 11. Marital Status  | 12. Was Decedent Ever in<br>Armed Forces?                               | 1 U.S. 13.   | Was Deceder                       | nt of Hispanic Or<br>y Cuban, Mexica      | rigin? (Spe<br>in, Puerto         | city Yes or No<br>Rican, etc.)    | -                  | 14. Race - Ameri<br>Black, White       |  |
| 36                  | s afte  | by Fi            | 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced  | 1 □ Yes 2 <b>7 N</b> o<br>If Yes, Give<br>Year or Dates:                | and the state of t | 1 🗆 Yes 2                         | XNo Specify:                              | :                                 |                                   |                    | Specify:                               |  |
| Maryland 21215-0036 | to hour   | ted t            | 15. Decedent's Edu  | cation  | 16a. Dece  | dent's Usual (                    | Occupation                                |                                   |                                   | 16b. K             | Whi<br>(ind of Business/li             |  |
| 215                 | hin 72  | plet             | (Specify only highest grad<br>Elementary/Secondary (0-12)   | e completed) College (1-4or 5+)   | (Give  | kind of work<br>DO NOT use        | done during mos<br>retired)               | st of worki                       | ng                                |                    |  |  |
| 21                  | ifiled will<br>Hygien<br>other th   | Completed        | 12  |   | Execu  | tive S                            | ecretary                                  |                                   |                                   |                    | craft                                  |  |
| and                 | be fill<br>d off  | Be               | 17. Father's Name (First, Middle, Last)   |   |  |                                   |   |                                   | (First, Middle,                   | Maiden             | n Surname)                             |  |
| ž                   | should<br>and Men<br>marke  | T <sub>o</sub>   | Peter A. Duzet  19a. Informant's Name/Relationship (Ty  | (ne Print)  | 19b Maili  | na Address (                      | 10000                                     |                                   | leller                            | er City o          | or Town, State, Zi                     | n Code)  |
|                     | d 2<br>F a r  |                  | Joseph R. Keene/hu  |   |  | -                                 |   |                                   |                                   |                    |  | MD 20904   |
| Je,                 | os 1 and<br>of Health<br>Item 27<br>other tr  |                  | 20a. Method of Disposition  | 1   | . Place of Dispo   | osition (Name<br>matory or other  | of<br>er place)                           | Dece                              | mber                              | 20c. L             | ocation - City or T                    | own, State                                       |
| Ē                   | Page<br>ment c  |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  |   | esapeak  | e Crem                            | atory                                     |                                   | 2005                              | Be1                | tsville,                               | Maryland   |
| Baltimore,          | permit. Pages 1 an<br>Department of Heal<br>Important; If Item 2<br>eny Injury or other<br>ance.  |                  | 21. Signature of Funeral Service Licens   | Heatter   | 01251 g  | 2.Name and<br>oing H<br>everlv    | Address of Facili<br>Come Crer<br>L. Hecl | <sup>lity</sup><br>matio<br>krott | n Servi                           | ice<br>. Cl        | P.O. Bo                                | x 784<br>e MD 21029                              |
|                     | T.  |                  | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only or  | ications that caused the de   | eath. Do not en  | ter the mode                      | of dying, such as                         | s cardiac o                       | r respiratory ai                  | rrest,             |  | Approximate<br>Interval Between                  |
| in                  | Physician   |                  | Immediate Cause (Final disease or condition   | Atheroscler   | otic He  | art Di                            | sease                                     |                                   |                                   |                    |  | Onset and Death                                  |
|                     | /Medical<br>Examiner  |                  | resulting in death)   | Due to (or as a cons  | sequence of):  |                                   |   |                                   |                                   |                    |  |  |
| W.                  | A 9   | er               | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a cons   | sequence of):  |                                   |   |                                   |                                   |                    |  |  |
|                     | uted<br>d<br>ansit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |   |  |                                   |   |                                   |                                   |                    |  |  |
| Ó                   | ate be executed hysician and he burial-transit  | Exa              | resulting in death) Last  | Due to (or as a cons  | sequence of):  |                                   |   |                                   |                                   |                    |  |  |
| 8760,               | hysici<br>the bu  | lical            |   | d   |  |                                   |   |                                   |                                   |                    |  |  |
| x 68                | leath certificate<br>attending phy<br>I for use as the  | /Mec             | IF FEMALE:  | 23c. If yes, outcome of pre   | gnancy   |                                   |   |                                   |                                   |                    | 004 0-44 4-5                           |  |
| Вох                 | atten<br>atten<br>I for u   | clan             | in the past 12 months?  | 1 Live birth 2 □ F<br>4 □ Pregnant at time of                           | etal death 3[  | Ectopic preg                      |   |                                   |                                   |                    | 23d. Date of deliv<br>Month            | Day Year   |
| o.                  | t the d<br>by the<br>achec  | hysi             | 1 ☐ Yes 2 ☐ XNo<br>9 ☐ Unknown  | 9□ Unknown  |  |                                   |   |                                   |                                   |                    |  |  |
| S,                  | <ul> <li>requires that the death cer</li> <li>been signed by the attendin</li> <li>should be detached for use</li> </ul>  | by Physician/Med | Part II. Other significant conditions con   | ntributing to death but not   | resulting in the u   | inderlying cau                    | ise given in Part I                       | l.                                | 23e. Did t                        | obacco             | use contribute to                      | the cause of death?                              |
| brd                 | equir<br>een si<br>ould I   |                  |   |   |  |                                   |   |                                   | 10                                | Yes 2              | XNo 3□Pro                              | bably 4 Unknown                                  |
| ec                  | a taw i<br>has b  | Completed        |   |   |  |                                   |   |                                   | 24a. Was<br>autop                 | osy                | 24b. Were aut<br>prior to co<br>death? | opsy findings available<br>ompletion of cause of |
| Vital Records,      | n: The  |                  |   |   |  |                                   |   |                                   | 1 Yes                             | rmed?<br>2 No      |  | 2 No   |
|                     | sicial<br>certi   | To Be            | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:<br>1 ☐ Inpatient 2  | ER/Outpatre  | nt 3 DOA                          | Other                                     |                                   | Check only o                      |                    | 6 ☐Other (Speci                        | .6.1   |
| o                   | g Phy<br>er this  | n: T             | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year                                 |  |                                   | c. Injury at<br>Work?                     |                                   | 28d. Describe I                   |                    |  | ,,,,   |
| iois                | endin<br>eath.<br>or; Aft   | atlo             | 1 Natural 5 Pending 2 Accident investigation  | (   | ,,,  | М                                 | 1   Yes 2                                 | ]No                               |                                   |                    |  |  |
| Division of         | Hospital or Attending Physician: The law requires that the death certifica 24 hours after death. Funeral Director: After this certificate has been signed by the attending phylieled in by the funeral director, page 2 should be detached for use as the ligh filled in by the funeral director, page 2. | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - A building, etc. (Spe                            | t home, farm, st<br>ecify)   | reet, factory, o                  | office                                    |                                   | 28f. Location (8<br>City or Tox   |                    | nd Number or Rui<br>9)                 | al Route Number,                                 |
|                     | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has complately filled in by the funeral director, page 2   | Medical (        | 29a. Certifier Check only one) Certifying Phy 2 Medical Exami   | sician: To the best of my liner: On the basis of examand manner stated. | knowledge, dear<br>ination and/or in   | h occurred at<br>ivestigation, in | the time, date an<br>n my opinion, dea    | nd place, a                       | and due to the<br>ed at the time, | cause(s<br>date an | and manner as<br>d place, and due      | stated.<br>to the cause(s)                       |
|                     | To the vithin 2 To the complet  | W                | 29b. Signature and title of certifier   | 11 1  |  | 29c.                              | License number                            |                                   |                                   | 29d. Da            | ite signed (Month                      | . Day, Year)                                     |
| 1                   | ha  |                  | Miles 1   | 1280XI  |  | Do                                | 04337                                     | 5                                 |                                   | 12                 | /14/05                                 |  |
| (C).                | (1)   |                  | 30. Name and address of person who co   |   | •  |                                   |   |                                   |                                   |                    |  |  |
|                     | Sta   | to               | Karen W. Merritt, 31. Date filed (Month, Day, Year)   | M.D. 3110 Gr  | anatură .  | 1                                 | Silver S                                  | Sprin                             | g, MD 2                           | 2090               | 4                                      |  |
| S.                  | Registi   |                  | DEC 16 2  | JUD PROPERTY  | Dr. M  | poste                             |   |                                   |                                   |                    |  |  |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Da</sup>¥16,2005 **Physician** VIRGINIA KROBOTH December LULIABELLE 1:30 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mt. Airy Frederick Kline Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F Yrs 71 Director 217-28-2120 January 30,1934 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examination unit by motified at 1 XYes 2 □ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 264 Longford Drive 21702 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental Hiam: If itam 27 is marked oth James Daniel Barger Helen Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 264 Longford Drive, Frederick, Md. 21702 Cheryl A. Cunningham r othar t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ö Cedar Lawn Memorial Pk. 12-21-05 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew K. Coffman Funeral Home, Inc. R. hoel 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Cancer of Lungs vear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ы Secondary in Liver Examiner burial-transit Chronic Lung Disease certificate be exec Due to (or as a consequence of): the attending physician Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Diabetes Mellitus, Hypertension 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 2 **X** No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other:  $_{4\,\square\, \text{Nursing Home}}$  5  $\square$  Residence 6  $\boxtimes$  Other (Specify)  $\square$  H O S  $\square$  ice 1 ☐ Yes 2 💢 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attanding P s after death. 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D54636 December 19. 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Syed W. Haque, 700 Montclaire Avenue, Frederick, MD 21701 MD 31. Date filed (Month Party ear) 0 2005 32. Registrar's Signature State Registrar

|           |  |                  | For State Registrar   |  | ryland / Depa                         |                                      | f Health a                              | nd Mental Hy                                       | giene                                   | 5 42334  |
|-----------|--|------------------|---|--|---------------------------------------|--------------------------------------|---|--|---|--|
| Q.        | of an way  |                  | Decedent's Name (First, Middle, La  | st)  |                                       | imouto                               | or Bouili                               | 2. Date of De                                      | Reg. No.                                | 3. Time of Death   |
|           | Physici<br>/Medic  |                  | Anna Mae Kimbl  | е  |                                       |                                      |   | Decemb   |   | Year<br>005 03:35 AM   |
|           | Examin   |                  | 4a. Facility Name (If not institution, giv  |  |                                       | 4b. City, Tow                        | n, or Location of                       |  | 4c. County of                           | of Death   |
| 1,275     |  |                  | Washington Count  |  |                                       | Hagers                               |   |  | Washi                                   |  |
|           | Funeral Director   |                  | 5. Social Security Number 6. S  | i⊟M 2⊠F  | (In yrs. last birthday) Yrs.          | If Under 1 Ye Months Da              |   | Min. (Month, Da                                    |   | Birthplace (State or Foreign Country)                                  |
| £.        |  |                  | 214-34-9399<br>Usual Residence of Decedent  |  | 68 Trs.                               |                                      |   | May 25   | , 1937 l                                | Maryland   |
|           | hours after death with the Maryland<br>turet', or Itams 23a or 28a-f show<br>al Examiner must be notified at   | _                | 10a. State 10b. County  |  | 10c. City, Town or Lo                 | ocation                              |   |  |   | 10d. Inside City Limits  |
|           | 8a-f s   | cto              | Maryland Washing  | ton  | Williams                              | port                                 |   |  |   | 1 AYes 2 No  |
|           | with the   | Funeral Director | 10e. Street and Number  |  |                                       | 10f. Zip Cod                         |   |  | 10g. Citizen of W                       | hat Country?   |
|           | eath   | eral             | 123 E. Potomac St   | reet  12. Was Decedent Ev  | ver in IIS 13                         | 2179                                 |   | in? (Specify Voc or No                             | USA                                     | - American Indian,   |
| ^         | r Itan   | Fun              | 1 Never Married 3 Married   | Armed Forces?  | 13.                                   | f Yes, specify C                     | Cuban, Mexican,                         | in? (Specify Yes or No<br>Puerto Rican, etc.)      | Black                                   | , White, etc.  |
| 2         | ral', o  | by               | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:   |                                       | 1□Yes 2⊠                             | No Specify:                             |  | Specify:                                | White  |
| 215-0036  | be filed within 72 hours after death with the Marylan Hygiene.  do other than "natural", or itams 23a or 28a-f show event, the Modical Examiner must be notified at  | Completed        | 15. Decedent's En<br>(Specify only highest gra  | Jucation<br>ade completed)   | 16a. Dece<br>(Give                    | dent's Usual Oc<br>kind of work do   | cupation<br>one during most (<br>tired) | of working   | 16b. Kind of Bus                        | iness/Industry   |
| 7         | within 72<br>ene.<br>then "net<br>he Medic   | mpl              | Elementary/Secondary (0-12)   | College (1-4or 5+)   | )                                     |                                      | tired)                                  |  |   | 0.1  |
| N         | filed<br>Hygie<br>ther<br>Int.   | Co               | 12<br>17. Father's Name (First, Middle, Last,   | , O  | Clerk                                 |                                      | 18. Mother                              | s Name (First, Middle,                             | Hardware                                |  |
| yıand     | ld be<br>ental<br>ked o<br>ic ev   | To Be            |   | Bryan  |                                       |                                      | Anni                                    |  |   | ,  |
|           | 2 should<br>and Men<br>is marke<br>aumatic   | -                | 19a. Informant's Name/Relationship (  |  | 19b. Mailir                           | ng Address (Str                      |   | or Rural Route Numbe                               |   | tate, Zip Code)  |
| , Mai     | 2 <b>4 2 1</b>   |                  | Earl B. Kimble S  | r. (Husband  | 1) 123 E                              | . Potom                              | ac St. 1                                | Williamspo   | -t, MD 2                                | 21795  |
| o<br>e    | of Head of Head of Other   |                  | 20a. Method of Disposition 1 XBurial 2 Cremation 3  | Removal from State   | 20b. Place of Dispo<br>cemetery, crer | sition (Name of<br>natory or other   | place)                                  | Date   | 20c. Location - C                       | ity or Town, State   |
| Ě         | permit. Pages<br>Department of<br>Important: If it,<br>any injury or o   |                  | 4 □ Donation 5 □ Other (Specif  | y)   | St. Paul'                             | s Cemet                              | ery De                                  | c. 19,2005   | Clear Sr                                | oring, MD  |
| baltimore | permit. I<br>Departm<br>Importer<br>any injur  |                  | 21. Signature of Funeral Service Lice   | Ksee<br>∧  | 0s                                    | , Name and Ad<br>borne F             | dress of Facility<br>uneral             | Home P.A.  | 425 S. Co                               | onococheague   |
| 2000      | 40260  |                  | 23a. Part 1. Enter the disease, or com  | elications that assumed the  | 31                                    | . WIIII                              | amsport                                 | , MU Z179:   | <u> </u>                                | Approximate  |
|           | Physician<br>/Medical<br>Examiner  | ner              | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a o  | consequence of):                      | into                                 | cramb                                   | l stroke   | <u> </u>                                | Interval Between<br>Onset and Death                                    |
|           | ate be executed<br>hysician and<br>the burial-transit  | Ilcal Examiner   | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last   | c  | consequence of):                      |                                      |   |  |   |  |
|           | certifica<br>nding ph<br>use as th   | Med              | IF FEMALE:  |  |                                       |                                      | 4                                       |  |   |  |
| ă         | death<br>e atter   | Physiclan/Med    | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of<br>1 ☐ Live birth 2:<br>4 ☐ Pregnant at tin<br>9 ☐ Unknown | ☐Fetal death 3 ☐                      | Ectopic pregna<br>Other (specify,    |   |  | 23d. Date<br>Monti                      | ,  |
| ecords, r | o the hospital or Attending Physician: The law requires that the within a 44 hours after decided that the confidence of the confidence of the completely filled in by the funeral director, page 2 should be detached. | þ                | Part II. Other significant conditions of  | ontributing to death but   | not resulting in the ur               | nderlying cause                      | given in Part I.                        |  |   | ute to the cause of death?   |
| <u>5</u>  | s beel   | ompleted         |   |  |                                       |                                      |   | 24a. Was   | an 24b. We                              | ere autopsy findings available   |
| ב<br>ב    | Ine la<br>te ha  | E                |   |  |                                       |                                      |   |  | med? de                                 | ere autopsy findings available<br>or to completion of cause of<br>ath? |
| NI G      | ntifica<br>ctor, p   | BeC              | 25. Was case referred to medical examiner?  |  |                                       |                                      | 26. Place o                             | 1 ☐ Yes of Death (Check only o                     |   | Yes 2□No   |
| 5         | nysic<br>his ce<br>Il dire   | ပ္               | 1 ☐ Yes 2 ☐ No  | Hospital: 1 ☑ Inpatient  | 2 ER/Outpatien                        | t 3 DOA                              | Other: 4 ☐ Nurs                         | ing Home 5 Resid                                   | lence 6 Other                           | (Specify)  |
| 5         | ing P  | <u></u>          | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Y   | 'ear) 28b. Time of Injury             | V                                    | njury at<br>Work?                       |  | ow injury occurred                      | 1  |
| NSION :   | death<br>death<br>stor: /  | cat              | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   |  | A11 (-                                |                                      | ☐Yes 2☐No                               |  |   |  |
| 2         | rs after (sal Directed in by   | Certificatio     | 4 Homicide determined   | building, etc. (   |                                       |                                      |   | City or Tow  | n, State)                               | or Rural Route Number,   |
| :         | i o the nospital of Attanding Physician: The law within 24 bours after death.  To the Funeral Diector: After this certificate has completely filled in by the funeral director, page 2 s                               | edical           | 29a. Certifier 1 ★ Certifying Ph<br>(Check only one) 2 ★ Medical Exam   | ysician: To the best of r<br>niner: On the basis of ex<br>and manner state         | xamination and/or inv                 | occurred at the<br>restigation, in m | time, date and<br>by opinion, death     | place, and due to the o<br>occurred at the time, o | cause(s) and manr<br>date and place, an | ner as stated.  d due to the cause(s)                                  |
| ı         | To To Com  | Σ                | 29b. Signature and title of certifier   |  |                                       |                                      | ense number                             |  | 29d. Date signed (                      | Month, Day, Year)  |
|           |  |                  | 1 / Jack  | , M.P.   |                                       | D                                    | 0244                                    | 0  | 12/17/6                                 | )5   |
| 24        | -2   |                  | 30. Name and address of person who  | 251 Ea   | th (Item 23a) (Type,<br>st Antiet     | Print)<br>Cm Str                     | eet Ho                                  | agorstoc   | on Mary                                 | land   |
|           | Sta<br>Registra  | _                | 31. Date filed (Month Day Year)   | 2005 32. Redistrar's   | s Signature                           | berte                                |   |  |   |  |

| -832           | . ROSE :  | CAL              | ricado rypo  |  | <b>delible Ink. Ensure A</b><br>artment of Health and                                 | •                                       | _                              |                                  |
|----------------|---|------------------|--|--|---|---|--------------------------------|----------------------------------|
|                |   |                  | For State State Registrar  |  | rtificate of Death  |   | 2005                           | 42335                            |
|                | Dhusisi   |                  | Decedent's Name (First, Middle, Last)  | <del></del>  |   | 2. Date of Death<br>Month               | Day Year                       | 3. Time of Death                 |
|                | Physici<br>/Medic   |                  | Summer Rose Karis  |  |   | DECEMBER                                | 10, 2005                       | 0010 A M                         |
| 7              | Examin  | er               | 4a. Facility Name (If not institution, give street an<br>CALVERT MEMORIAL HOSE   |  | 4b. City, Town, or Location of Deat PRINCE FREDERICK                                  |   | 4c. County of Dea              | th                               |
|                | Funeral   |                  | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last birthday)   | tf Under 1 Year If Under 24 Hrs Months Days Hours Min.                                |   |                                | thplace (State or Foreign        |
|                | Director  |                  | 213-06-9180 1□M 2  Usuat Residence of Decedent   | 25 Yrs.  | World's Days Hours Will.  | 9/10/19                                 | 80                             | D.C.                             |
|                | land<br>ow  |                  | 10a. State 10b. County   | 10c. City, Town or Lo  | ocation   |   |                                | 10d. Inside City Limits          |
|                | a-f sh  | ctor             | MD Calver  | t  | Chesapeake Be   | each                                    |                                | 1 X Yes 2 □ No                   |
|                | ours after death with the Maryland<br>rai', or items 23e or 28e-f show<br>Examiner must be notified at                    | Funeral Director | 10e. Street and Number   |  | 10f. Zip Code   | 10g                                     | . Citizen of What Co           | ountry?                          |
|                | eath v  | erai             | 7697 Old Bayside R   |  | Was Decedent of Hispanic Origin? (5   | pecify Yes or No-                       | USA<br>14. Race - Ame          | arican Indian.                   |
|                |   | Fun              | t ☑ Never Married 2 ☐ Married 1 ☐  | Yes 2 TrNo   | Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puer           | to Rican, etc.)                         | Btack, Whit                    |                                  |
| 21215-0036     |   | d by             | 3 Widowed 4 Divorced Year  | or Dates:  | 1 ☐ Yes 2 ☑ No Specify:   |   |                                | Mite                             |
| 15-            | na 72   | Completed        | 15. Decedent's Education<br>(Specify only highest grade comple   | (Give  | dent's Usual Occupation<br>kind of work done during most of wo<br>DO NOT use retired) | rking 16                                | b. Kind of Business            | /Industry                        |
| 212            | d within<br>giene.<br>In then   | mo               | Elementary/Secondary (0-12) Colle  | ege (1-4or 5+)   | Carpenter   | I                                       | Exhibit                        | Company                          |
| pu             | be filed<br>tal Hygi<br>d other<br>event, I   | Be               | 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Na   | me (First, Middle, Ma.                  | iden Sumame)                   |                                  |
| Maryland       | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other then<br>aumatic avent, the Mi                          | 2                | William E. Karis  19a. Informant's Name/Relationship (Type, Print  | 19h Mailie   | Tamm  | y M. Rasi                               |                                | Zin Cada)                        |
| Ma             | s 1 and 2 should be filed<br>I Health and Mental Hyg<br>Itam 27 is marked oths<br>other traumatic avant,                  |                  | Tammy Raskhodoff/Mo  |  | Old Bayside R   |   |                                |                                  |
| ore,           | of Health<br>of Health<br>of item 27 if<br>item 27 if   |                  | 20a. Method of Disposition t XBurial 2 ☐ Cremation 3 ☐ Removal   | 20b. Place of Dispo  |   |   | c. Location - City or          |                                  |
| Baltimore,     | Pagitment tant: h   |                  | 4 ☐ Donation 5 ☐ Other (Specify)   | S. Memo  | rial Gdns.12/1  | .9/05 <u>Du</u>                         | nkirk,M                        | aryland                          |
| Bal            | permit. Pages<br>Department of i<br>Important: If it<br>any injury or o   |                  | 21. Signature of Funeral Service Licensee  |  |   | ymond-Wo                                |                                | , P.A.                           |
|                |   |                  | 23a. Part1. Enter the disease, or complications  | that caused the death. Do not ent  | O Box 430, Dur the mode of dying, such as cardia                                      |   |                                | Approximate<br>Interval Between  |
|                | Physician   | 2 4              | shock, or heart failure. List only one cause<br>Immediate Cause (Final<br>disease or condition   | AUCTIPLE DM  | Jales .   |   |                                | Onset and Death                  |
|                | /Medical<br>Examiner  |                  | resulting in death)  | ue to (or as a consequence of):  |   |   |                                |                                  |
|                |   | e.               | Sequentially list conditions, b.   | ie to (or as a consequence of):  |   |   |                                |                                  |
|                | ruted<br>id<br>ansit  | Examiner         | Sequentially list conditions, if any, leading to infinediate cause. Either Underlying Cause (Disease or injury that initiated events c.  |  |   |   |                                |                                  |
| ,09,           | be executed<br>icien and<br>burial-transit  |                  | resulting in death) Last Du  | ue to (or as a consequence of):  |   |   |                                |                                  |
| 6876           |   | dical            | d.   |  |   |   |                                |                                  |
| Box 6          | leath certificate t<br>attending physic<br>I for use as the b   | n/Me             |  | s, outcome of pregnancy  |   |   | 23d. Date of de                | livery                           |
|                | requires that the death certificate<br>een signed by the attending phys<br>hould be detached for use as the               | Physician/Medic  | in the past 12 months?   |  | Ectopic pregnancy Other (specify)   |   | Month                          | Day Year                         |
| P.0            | that the de<br>ed by the a<br>detached  | Phy              | Part II. Other significant conditions contributing   |  | nderlying cause given in Part I   | 23e Did tobac                           | co use contribute to           | o the cause of death?            |
| ds,            | uires t<br>signe<br>Id be   | d by             | , and a second s | ,  | nuonymy cause great mir att i.  | 1 ☐ Yes                                 | /                              | robably 4 Dunknown               |
| Vital Records, | N S CI  | Completed        |  |  |   | 24a. Was an                             | 24b. Were a                    | utopsy findings available        |
| R              | sician: The law<br>certificete has b<br>rector, page 2 si   | Som              |  |  |   | autopsy<br>performed<br>1 P Yes 2       | d? death?                      | completion of cause of<br>2 ☐ No |
| Vita           | Physician:<br>rthis certific<br>ral director,   | Be               | 25. Was case referred to medical examiner?  Hospital:  |  | Other   | ath (Check only one)                    |                                |                                  |
| ō              | Physical distriction  | n: To            | M 162 5 140  | 1 ☐ Inpatient 2 ☒ ER/Outpatier  Date of Injury (Month, Day Year)  28b. Time o tnjury | IL 3 DOA 4 INUISING   | lome 5 ☐ Residence<br>28d. Describe how |                                | cify)                            |
| ion            | Attanding I<br>ir death.<br>actor: After<br>by the funer  | atio             | Accident investigation   | (Month, Day Year) thiury   | P M 1 Yes 2 10  | priveno                                 | FCDR,                          | e Jecren                         |
| Division       | or Atti   | Certification:   | 3 Suicide 6 Could not be determined 28e.   | Ptace of Injury - At home, farm, str<br>building, etc. (Specify)                     | eet, factory, office  | 28f. Location (Stree<br>City or Town, S | State)                         |                                  |
| ш              | Hospital<br>Hours a<br>Funeral (<br>Tely filled   |                  | 29a. Certifier 1☐_Certifying Physician: 1  | To the best of my knowledge, deat  | h occurred at the time, date and place  | e, and due to the caus                  |                                |                                  |
|                | To the Hospital or Attandi<br>within 24 hours after death<br>To tha Funeral Diractor: A<br>completely filled in by the fi | Medical          | (Check only 2 Medical Examiner: On   | the basis of examination and/or in manner stated.                                    | vestigation, in my opinion, death occi  | urred at the time, date                 | and place, and due             | o to the cause(s)                |
|                | To t<br>To t  | Σ                | 29b. Signature and title of certifier  | 16 1   | 29c. License number  OCME   |   | Date signed (Mont<br>CEMBER 11 |                                  |
|                |   |                  | 30. Name and address of person who completed   | I cause of death (Item 23a) (Type,   |   |   |                                | , 2003                           |
|                | 5   |                  | HAMPEN P. K  |  | ENN STREET, BALTI   | MORE, MARY                              | YLAND 2120                     | 01                               |
|                | Sta   |                  | 3 Date filed (Month, Day, Year)  | 32. Registrats Signature   | Sand B  |   |                                |                                  |
| DHI            | Registi   |                  | DEC 13 20  | 05 Seems &   | 1911  |   |                                |                                  |

MICHAEL H. KINNAMON 05-08743 Unpend item#23a,PII,27,perME,g351,1/3)/06 TI
State of Manyland / Department of Health and Mental Hygiene RKD 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** DECEMBER 25, MICHAEL HARRY KINNAMON 12:30P. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT <u>30310 HARRIS RANGE ROAD</u> CORDOVA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**X** M 2□ F Months Days Hours Min Yrs Director 218-58-2343 54 DEC. 5, 1951 MD Usual Residence of Decedent Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28e-f ehov the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No **CORDOVA** MD TALBOT the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a 30310 HARRIS RANGE ROAD Funeral 21625 **USA** 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No 1971—
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 end 2 should be filed within 72 hours atter c Department of Health and Mental Hygiene. Important: if item 27 is marked other then "neturel", or item eny Injury or other treumatic event, the Medical Examinar once. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced ear or Dates: 1974 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 WATERMAN SEAFOOD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN KINNAMON MARY PALMER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD ROE/SON 502 SEYMOUR AVE., ST. MICHAELS, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE CEMETERY 12/29/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK RD., CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on bach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Diabetic Ketoacidosis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown signed I d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Cirrhosis of Liver 2 No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death.

1 ☐ Yes 2 ☐ No 24a. Was an certificate has i 1 Yes 2 No or Attending Physicien: director. Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE ို 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funerel Direct completely filled in by 4 | Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) well MOMINTE O.C.M.E. DECEMBER 26, 2005

State Registrar

31. Date filed (Month, Day, Year) KUREU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET BALTIMORE MARYLAND 21201

State of Maryland / Department of Health and Mental Hygiene 62337 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 28, 2005 9:45 AM M Patricia A. Key /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9122 Old Burton Circle Prince George's Upper Marlboro If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 200F 52 1958 Washington, D.C. 579-68-1089 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene.
ant: if Item 27 ie marked other than "natural", or Items 23a or 28a-f show ary or other traumatic event, "a Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland Upper Marlboro 1ÆYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20772 9122 Old Burton Circle U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Bodzin & Golub, P.C. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Elmer R. Kev 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3032 Clifton Park Terrace Baltimore, Maryland 21213 Mrs. Chanda Key-Curry (Daughter) December 10, 205 Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2/2/Cremation 3 ☐ Removal from State permit, Page Department of Important: if any injury or once. Beltsville, Maryland Chesapeake Crematory, Inc. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. maleson 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off attending physician and for use as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sickle Hemoglobin C Disease 1 ☐ Yes 2XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 s has 2**X** No 1 ☐ Yes after death.

J Diractor: After this certifice of in by the funeral director, I To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA ို 1XYes 2 □ No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) 11701 Livingston Rd. Suite 209 Ft. Washington, Maryland 20744 Obiora Ogbuewa, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State BEC 1 3 2005 Registrar

| Josep<br>05-08             |  | ne                   | Kahoe III   | Please 1  | Type or Pr   | int in                | Black I                         | ndelil               | ble Ink                  | c. Ensi          | ure Ali      | Copies                           | Are              | Legible                                   |  |
|----------------------------|--|----------------------|---|---|--|-----------------------|---------------------------------|----------------------|--------------------------|------------------|--------------|----------------------------------|------------------|---|--|
| CT _                       |  |                      | 1 - For 12-14-05<br>Registrar Amend #4  | o.& 28f.  | State of No. PerMEO PG   | Marylaı<br>C. cm      |                                 |                      |                          | Health<br>Death  |              | -                                | giene<br>Reg. No | 2005                                      | 42338  |
|                            | Physical /Media  | cal                  | Doseph Os      Joseph Os      Facility Name (If not ins)  | born  | e Kahoe  | , II                  | I                               | 4h C                 | City Town                | or Location      |              | 2. Date of De<br>Month<br>Decemi | ber              | 7 2005<br>County of De                    | 3:24 A M   |
|                            | Examir<br>Funeral  | ier                  | Route 210 @ I   | •   | Hill Roa   | d                     | . last birthda                  | <del>-0x</del>       |                          | <del>11</del> 02 | Kon Hi       | Date of Bir                      | P:               | rince (                                   | George's   |
|                            | Director   |                      | 223-08-846<br>Usual Residence of Decede   |   | <b>X</b> M 2□F   |                       | 30 Yrs.                         | Mont                 | hs Days                  | Hours            | Min.         | July                             | 24,              | (   | Country)<br>rginia                                 |
|                            | e Marylan<br>3e-f ehow<br>diffied at   | ctor                 | VA Pr   |   | William  |                       | ity, Town or<br>odbr:           |                      |                          |                  |              |                                  |                  | -   | 10d. Inside City Limits 1 ☐ Yes 2 🛱 No             |
|                            | th with th   | Funeral Director     | 10e. Street and Number 6262 Tenor   | Court   | t  |                       |                                 |                      | Zip Code<br>2193         | 3                |              |                                  | 10g. Cit         | tizen of What (                           | Country?   |
| 036                        | urs atter death with the Maryla<br>el', or items 23a or 28e-f ehov<br>Examiner must be mytiffed at   | þ                    | 11. Marital Status 1   Never Married 2  3 □ Widowed 4 □ Div   | ] Married   | 12. Was Deceder<br>Armed Forces<br>1 ☐ Yes 22<br>If Yes, Give<br>Year or Dates | s?<br>] No            | J.S. 13                         | If Yes, s            | specify Cubs             | oan, Mexicai     | n, Puerto Ri | ify Yes or No<br>ican, etc.)     | )-               | 14. Race - An<br>Black, Wh<br>Specify: B1 | nite, etc.   |
| Maryland 21215-0036        | filed within 72 hours after death with the Maryland<br>Hygione.<br>other than "naturel", or items 23a or 28e-f ehow<br>ent, the Madical Examiner must be notified at | Completed            | 15. Dec<br>(Specify only<br>Elementary/Secondary (0   |   | cation<br>e completed)<br>College (1-40  | r 5+)                 | (Giv                            | e kind of<br>DO NO   | T use retire             | durina mos       |              | 7                                |                  | ind of Busines                            | s/Industry Company                                 |
| yland 2                    | nd 2 should be filed within :<br>Ith and Mental Hygiene.<br>27 is marked other than "r<br>rtraumatic event, the Mad  | To Be C              | 17. Father's Name (First, M.<br>Joseph Osbo   | rne E   |  | Jr.                   |                                 |                      | 7 10                     | 18. Mothe        |              | First, Middle,<br>H <b>ill</b>   |                  |   | Company  |
|                            | s 1 and 2 sho<br>of Health and<br>item 27 is m   |                      | 19a. Informant's Name/Rela  |   |  |                       | 6262                            | 2 Te                 | nor                      |                  | woodk        | ridge                            |                  | or Town, State,<br>7A 221                 |  |
| Baltimore,                 | Pages<br>nent of<br>ant: If if   |                      | 20a. Method of Disposition  | ner (Specify)                                     |  |                       | Place of Disponder, cr<br>lemar | ematory o            | or other pla<br>mete     | ry               |              | /05                              | Fair             | cation - City o                           | o.,VA  |
| Ba                         | permit. Departr Imports any inj  |                      | 21. Signature of Funeral Se   | Thus  | V  |                       | 8                               | 314                  | Fran                     | klin             | St           | Alexa                            | andr             | eral H<br>cia,VA                          | ome<br>22314                                       |
| •                          | Physician<br>/Medical<br>Examiner  |                      | 23a. Part1. Enter the disea<br>shock, or heart failure<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | se, or compli<br>List only on                     | ie cause on each   | ole                   | injus                           | 1                    | node of dyi              | ing, such as     | cardiac or r | espiratory ar                    | rrest,           |   | Approximate<br>Interval Between<br>Onset and Death |
| o,                         | vate be executed shysicien and the burial-transit  | Examiner             | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   |   | Due to (or a   |                       |                                 |                      |                          |                  |              |                                  |                  |   |  |
| Box 68760                  | tificate be og physicier as the buri   | edicai               |   | d   |  |                       |                                 |                      |                          |                  |              |                                  |                  |   | 4  |
| .О. Вох                    | ne death cer<br>the ettendir<br>hed for use  | by Physician/Medicai | IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | IL I  | 3c. If yes, outcom<br>1□Live birth<br>4□Pregnant a<br>9□ Unknown               | 2 Feta                | ıl death 3                      | □Ectopic<br>□ Other  | pregnancy<br>(specify)   | у                |              |                                  | 2                | 23d. Date of de<br>Month                  | elivery<br>Day Year                                |
| <u>α</u>                   | w requires that the been signed by should be detac   |                      | Part II. Other significant co   | nditions con                                      | tributing to death   | but not res           | ulting in the                   | underlyin            | g cause giv              | ven in Part I.   |              | 23e. Did to                      |                  |   | o the cause of death?                              |
| l Reco                     |  | Completed            |   |   |  |                       |                                 |                      |                          |                  |              |                                  |                  | 24b. Were a prior to death?               | utopsy findings available completion of cause of s |
| f Vita                     | Physician: The this certificate ral director, pag  | To Be                | 25. Was case referred to me examiner?  1 ※ Yes 2 □ No   |   | ospital:<br>1 ☐ Inpat  | ient 2                | ER/Outpatie                     | ent 3□               | DOA Oth                  | 300              |              | Check only or                    | 157              | X⊠Other (Spe                              | ~  |
| Division of Vital Records, | fe fi  | Certification: 1     | 21 Accident in<br>3 Suicide 6 □ C   | ending<br>vestigation<br>ould not be<br>etermined | 28a. Date of Inj<br>(Month, D.<br>2 - 7 -                                      | ury<br>ay Year)<br>05 | 28b. Time<br>Injury<br>03!      | of 17 M              | 28c. Injur<br>Wor<br>1 🗆 |                  | No 280       | 1. Describe h                    | ow injury        | occurred<br>Motor                         | vehicle<br>lision<br>Jural Route Number            |
| ā                          | Hoepi<br>24 hou<br>Fune<br>fely fii  | Medicai Cer          | COLOCK OTHY COLONIEL  | tifying Phys<br>lical Examin                      | ician: To the bes  | t of my kno           | St<br>swiedge dea               | th occurrenvestigati | ed at the tir            | me, date and     | OXO          | n Courte                         | 201              | 1411                                      | s stated.  |
|                            | To the To the complete   | Med                  | 29b. Signature and title of ce  |   | and manner s   | tated.                | 00 0                            |                      | 29c. Licens              | se number        |              |                                  |                  | signed (Moni                              |  |
| CR                         | (14)   |                      | 30 Name and address of pe   | rson who cor                                      | mpleted cause of   | death (Item           |                                 |                      |                          | CME              | 00t T        |                                  |                  | nber 7,                                   |  |
|                            | Sta<br>Registr   |                      | 31. Date filed (Month, Day, 1   |   |  | rar's Signa           |                                 |                      | ı ren                    | ui otre          | eet 1        | oartimo                          | ore,             | Maryla                                    | and 21201  |

|   |                | 1 - For<br>State<br>Registrar  | State of N  | Marylar  |                        |                                | of Health<br>of Death             |                 | -                               | giene<br>Reg. No. | 05                          | 42339  |
|---|----------------|--|---|--|------------------------|--------------------------------|-----------------------------------|-----------------|---------------------------------|-------------------|-----------------------------|--|
| Physic  | ian            | Decedent's Name (First, Middi  | , ,   |  |                        |                                |                                   |                 | 2. Date of De<br>Month          | ath<br>Day        | Year                        | 3. Time of Death                             |
| /Medi   | cal            | LEROY OWEN LEW   |   |  |                        | 4h Cihi To                     | wn, or Location                   | of Dooth        | Dec                             | 14                | 2005<br>ounty of Death      | 4:30 AM                                      |
| Exami   | ner            | 4a. Facility Name (If not institution  |   |  | i = = =                |                                |                                   |                 |                                 | 40.00             |                             |  |
| Funeral   |                | Genesis Healt  5. Social Security Number   | 6. Sex 7  |  | ines<br>last birthday) | If Under 1                     |                                   | r 24 Hrs.       | 8. Date of Bir<br>(Month, Da    | th Year)          | Talbo<br>9. Birth           | place (State or Foreign<br>ntry)             |
| Director  |                | 225-16-1458  | 1 <b>X</b> M 2□F                                  |  | 86 Yrs.                | Months [                       | Days Hours                        | Min.            | AUG. 24                         | ,1919             |                             | GINIA  |
| and w   |                | Usual Residence of Decedent  10a, State 10b, County  | ,   | 10c. Cit   | y, Town or Lo          | ocation                        |                                   |                 |                                 |                   |                             | 10d. Inside City Limits                      |
| Maryli<br>1 sho   | ō              | MARYLAND TALBO   |   |  | STON                   |                                |                                   |                 |                                 |                   |                             | 1X Yes 2 □ No                                |
| r 28a-  | Directo        | 10e. Street and Number   | 1   | LA   | JION                   | 10f. Zip C                     | ode                               |                 |                                 | 10g. Citize       | n of What Cou               | intry?                                       |
| th with   |                | 47 PARK LANE   |   |  |                        | 216                            | 501                               |                 |                                 | UNI               | TED STA                     | ATES   |
| ING Z I Z I 3-UU30 be tiled within 72 hours atter death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at  | Funerai        | 11. Marital Status   | 12. Was Decede<br>Armed Force                     | s?   | .S. 13.                | Was Deceder                    | t of Hispanic Or<br>Cuban, Mexica | rigin? (Sp      | ecify Yes or No<br>Rican, etc.) | 14.               | Race - Amen<br>Black, White |  |
| s atte  | by Fu          | 1 ☐ Never Married 2 🔀 Mar<br>3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give                                      | □No WW.  | II                     | 1 ☐ Yes 2 💆                    |                                   |                 |                                 |                   | pecify:                     |  |
| Z15-UU36 thin 72 hours at e. an "natural", or   | ed b           |  | Year or Date:                                     | S:   | 16a, Dece              | dent's Usual (                 | Occupation                        |                 |                                 | 16b. Kind         | of Business/Ir              | LTE<br>ndustry                               |
| within 72 and 1. Then "nell then | piet           | (Specify only higher Elementary/Secondary (0-12)   | st grade completed)  College (1-4c                | × 5 . \  | (Giva                  | kind of work<br>DO NOT use     | done durina mo:                   | st of work      | ing                             |                   |                             | ,  |
| A with  | Completed      | 12   | Conage (1940                                      |  | SALESI                 | MAN                            |                                   |                 |                                 | LIFE              | INSUR                       | ANCE   |
| be tiled tal Hygind of other event, in  | Be (           | 17. Father's Name (First, Middle,  | Last)   |  |                        |                                | 18. Moth                          | ner's Nam       | e (First, Middle                | , Maiden Su       | ımame)                      |  |
| aryland Z<br>should be tiled<br>and Mental Hygi<br>marked other<br>umatic event,  | 2              | RICHARD LEROY  |   |  |                        |                                |                                   | _               | ICE HAY                         |                   |                             |  |
| Maryland d 2 should be tile th and Mental Hy ?? Is marked oth traumatic event   |                | 19a. Informant's Name/Relations  |   |  |                        | 97                             | Street and Numb                   |                 |                                 |                   |                             | p Code)                                      |
| ITIMOTE, MARYIS it. Pages 1 and 2 should runent of Health and Mer runt: If item 27 is marke njury or other traumatic.   |                | 20a. Method of Disposition   | WIS (WIFE)  | 20b. F   | Place of Dispo         | ARK LAI<br>osition (Name       | of !                              |                 | ARYLAND                         |                   | L<br>tion - City or T       | own, State                                   |
| Pages<br>nent ot<br>nnt: If it  |                | 1 ☐ Burial 2 📆 Cremation<br>4 ☐ Donation 5 ☐ Other (5  |   | 10   |                        | matory or other                |                                   | 19/15           | 12005                           |                   |                             |  |
| Baltimore, permit. Pages 1 an Deportment of Heal Important: If item 2 any njury or other once.  |                | 21. Signature of Funeral Service   |   | UHE  | The second second      | E CREMA  2. Name and           |                                   | and the second  | 5/2005                          |                   | ENSVIL                      | L HOME, P.A                                  |
| B Per Suppose   |                | Sharran  | X (00)  | itt  |                        |                                | , HELFEN<br>MROCK RO              |                 | CHESTER                         |                   |                             |  |
| Physician /Medical Examiner e prize | Examiner       | 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a   | as a consequence as a c | quence of):            | rdiod                          | c can                             | rdion           | lij-e as                        | Her               |                             | Approximate Interval Between Onset and Death |
| Hecords, P.O. Box 68/6U,  The law requires that the death certiticate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | n/Medicai      | IF FEMALE: 23b. Was decedent pregnant  | d. 23c. If yes, outcor                            |  |                        |                                |                                   |                 |                                 | 230               | d. Date of deliv            | rery   |
| the death<br>y the atte   | Physician/Med  | in the past 12 months? 1 Yes 2 No 9 Unknown  | 1 □Live birth 4 □ Pregnant 9 □ Unknowr            | t at time of o   |                        | ⊒Ectopic preg<br>⊒ Other (spec |                                   |                 |                                 |                   | Month                       | Day Year                                     |
| ecords, P.O. I<br>law requires that the de-<br>as been signed by the a  | b              | Part II. Other significant conditi   | ons contributing to death                         | h but not res  | sulting in the u       | inderlying cau                 | se given in Part                  | 1. '<br>1 2 1 4 | 23e. Did t                      | _                 |                             | the cause of death?                          |
| w require   | Completed      |  | reare   | En   | har-                   | 2 /                            | 170                               |                 | 24a. Was                        | an 2              | 24b. Were aut               | opsy findings available                      |
| The law   | duc            |  |   | (0)  | (0)                    |                                |                                   |                 |                                 | rmed?             | death?                      | ompletion of cause of<br>2 No                |
| VICAL P   | 0              | 25. Was case referred to medical   | ıl  |  | <del></del>            |                                | 26. Plac                          | e of Deat       | 1 ☐ Yes<br>h (Check only o      | 2 No              | 1 ☐ Yes                     | 2   140                                      |
|   | To B           | examiner? 1 Yes 2 No   | Hospital: 1 ☐ Inpa                                | atient 2   | ER/Outpatier           | nt 3 DOA                       | Other                             | /               | me 5 Resi                       |                   | Other (Speci                | fy)  |
| ng Ph<br>ng Ph<br>tter th   |                | 27. Manner of Death 1 ☐ Natural 5 ☐ Pendi  | 28a. Date of I                                    | njury<br>Day Year)   | 28b. Time o<br>Injury  | f 28c                          | . Injury at<br>Work?              |                 | 28d. Describe                   | how injury o      | ccurred                     |  |
| or Attending or Attending of Attendenth. Director: Atten in by the tune   | cati           |  | igation   |  |                        | М                              | 1 ☐ Yes 2 ☐                       | ]No             |                                 |                   |                             |  |
| DIVISION OF  I or Attending Physiater death.  Director: After this d in by the tuneral d  | Certification: | 4 Homicide determ  | nined 286. Place of                               | etc. (Special  | ome, farm, sti<br>fy)  | reet, factory, o               | office                            |                 | City or To                      |                   | lumber or Hur               | al Route Number,                             |
| DIVISION To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | Medical Ce     | (Check only 2 Medical  | ng Physician: To the be<br>Examiner: On the basis | s of examina   |                        |                                |                                   |                 |                                 |                   |                             |  |
| o the<br>lithin 2<br>o the<br>ample   | Med            | one) 29b. Signature and title of certain   | and manner  | stated.  |                        | 29c. L                         | icense number                     |                 | - T                             | 29d. Date s       | signed (Month,              | Day, Year)                                   |
| F 3 F 8   |                | 1/1/   | 19-60   | ML   |                        |                                | 025                               | 750             |                                 | 12                | 114/0                       | · 5  |
|   |                | 30. Name and address of person   | who completed cause of                            | of death (Iter   | m 23a) (Type.          | Print)                         | - 1, 0                            |                 |                                 | /                 | 1/                          |  |
| 10 KK   |                | Robert B. Sc   |   |  |                        |                                | e East                            | on.             | MIN.                            | 2160              | >1                          |  |
| St<br>Regist  | ate            | 31. Date filed (Month, Day, Year   | 32. Regi  | star's Signa   | ature                  | book.                          |                                   |                 |                                 |                   |                             |  |

DHMH 17 Rev 1/2001

Owen Lewis

|                     |  |                | 1 - For<br>State<br>Registrar  | State                                 | of Marylar  |   |                       | nt of Heate of De                       |                                  | Mental Hy                               | /giene               | . 0 0 0                        | 4234  | 0     |
|---------------------|--|----------------|--|---------------------------------------|---|---|-----------------------|---|----------------------------------|---|----------------------|--------------------------------|---|-------|
|                     | - 8  |                | 1. Decedent's Name (First, Midd  | le, Last)                             |   |   |                       |   |                                  | 2. Date of D                            | eath                 |                                | 3. Time of Dea                                | ıth   |
|                     | Physici<br>/Medic  |                | Rosa Belle   | e Lee                                 |   |   |                       |   |                                  | Decemi                                  | oer 1                |                                |   | A M   |
|                     | Examin   |                | 4a. Facility Name (If not institutio   | n, give street and n                  | umber)  |   | 4b. City              | , Town, or Lo                           | cation of Dea                    | th                                      | 4c                   | . County of De                 | ath   |       |
|                     |  |                | Southern 1   | Maryland                              | Hospita]  | L                                       |                       |   | inton                            |   |                      | Prince                         | George's                                      |       |
|                     | Funeral  |                | 5. Social Security Number  | 6. Sex<br>1 ☐ M 2 ☐ F                 | 7. Age (In yrs.                                       | • | If Und<br>Months      |   | f Under 24 Hrs<br>Hours Min      | . (Month, D                             | av. Year)            |                                | rthplace (State or Fo                         | reign |
|                     | Director   |                | 218-22-3115  | '\' 'X'                               | 3   | 30 Yrs.                                 |                       |   |                                  | Apr. 7                                  | , 19                 | 925 V                          | irginia                                       |       |
|                     | and we   |                | Usual Residence of Decedent<br>10a. State 10b. County                              | ,                                     | 10c. Ci   | ty, Town or Lo                          | cation                |   |                                  |   |                      |                                | 10d. inside City Li                           | mits  |
|                     | Mary   | ច              | Maryland Princ   | ce George                             | 1 .   |   |                       | Coni                                    | +o1 Wo                           | i ahta                                  |                      |                                | 1 Tyes 2                                      | ] No  |
|                     | the 28a  | Director       | 10e. Street and Number   | ce dedige                             | 5   |   | 10f. Z                | ip Code                                 | tol He                           | Ignus                                   | 10a. Cit             | tizen of What C                | 21  |       |
|                     | 3a or  |                | 1009 Epwort  | h Way                                 |   |   |                       |   | 20743                            |   | •                    |                                | d States                                      |       |
|                     | death  | Funeral        | 11. Marital Status   | 12 Was De                             | cedent Ever in U                                      | J.S. 13. \                              | Was Dec               | edent of Hispa                          | anic Origin? (S                  | Specify Yes or N<br>rto Rican, etc.)    | 0-                   | 14. Race - Arr                 | erican Indian,                                |       |
| 9                   | or Ite   | Ē              | 1 Never Married 2 Mar  | ned 1 Yes                             | orces?<br>2 No  |   |                       | 77                                      |                                  | rto Rican, etc.)                        |                      | Black, Wh                      |   |       |
| ဋ္ဌ                 | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or items 23a or 28a-f ahow<br>ha Medical Examinar must be notilled at   | d b            | 3X Widowed 4 □ Divorced  | Year or                               |   |   | I L Yes               | ZALINO :                                | Specify:                         |   |                      | Specify:                       | Black   |       |
| ς.                  | 72 h   | Completed      |  | nt's Education<br>est grade completed | 1)  | (Give                                   | kind of w             | ual Occupatio                           | n<br>ing most of wo              | orking                                  | 16b. K               | ind of Busines                 | s/industry                                    |       |
| 2                   | hen hen  | ם              | Elementary/Secondary (0-12)  | College                               | (1-4or 5+)  | life. L                                 |                       | use retired)                            |                                  |   |                      |                                |   |       |
| 2                   | lled v<br>tygie<br>her t   | ပိ             | 12th 17. Father's Name (First, Middle,   | ( act)                                |   |   |                       | Homema                                  |                                  | (Sina Adidd)                            | Majetas              |                                | vate  |       |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  The man in the maryla marked other than "natural", or thems 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. | Be             |  | H. Baker                              |   |   |                       | 10                                      | . MULTER STVA                    | me (First, Middle                       | . Whi                |                                |   |       |
| Ξ                   | hould<br>d Me<br>mark<br>matic   | ဠ              | 19a. Informant's Name/Relations  |                                       |   | 19h Mailin                              | a Addres              | es (Street and                          | Number or P                      | ural Route Numb                         |                      |                                | Zin Codo)                                     |       |
| <u>8</u>            | od 2 sellth and 27 is trau   |                | Rosetta L. Sk  | 60                                    | *h+o*   | 1                                       |                       |   |                                  |   |                      |                                |   |       |
| <u>ම</u>            | Hea<br>Hea<br>tem  | . 4            | 20a. Method of Disposition   | lates/Dau                             |   | Place of Dispo<br>cemetery, cren        | sition (Na            | worth<br>me of Par                      | way, ca                          | apitol H                                |                      | cation - City o                |   |       |
| E<br>0              | age:   |                | 1 XBurial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S                               |                                       |   | ue Rid                                  |                       |   |                                  | 17/05                                   | р                    | roperit                        | - X - WV                                      |       |
| altimore,           | mit. f<br>partm<br>ortar<br>Inju   | - 1            | 21. Signature of Fundral Service   |                                       | 1   |   |                       | and Address of                          |                                  | Stewart                                 |                      | -                              | •   | -     |
| m                   | Depa<br>Impo   |                | horing I   | Slew                                  | III VADE  |   |                       | 4001 B                                  | enning                           | Rd., N.                                 | E. W                 | ash., I                        | C 20019                                       |       |
|                     |  |                | 23a. Part1. E ter the disease, o shock, a heert failure. List                      | r complications that                  | caused the deal                                       | th. Do not ente                         | er the mo             | ede of dying, s                         | such as cardia                   | c or respiratory a                      | ırrest,              |                                | Approximate<br>Interval Between               |       |
|                     | Pnysician  |                | Immediate Couse (Final disease or condition  | 5                                     | e20514  | 5                                       |                       |   |                                  |   |                      |                                | Onset and Death                               |       |
|                     | /Medical   |                | resulting in death)  | aDue to                               | or sa consec  | uenge df):                              | 1                     |   | ,                                |   |                      |                                |   |       |
|                     | Examiner   |                | Sequentially list conditions   | b 1                                   | +cute   | Ken                                     | 4                     | 10                                      | 1/4 re                           | 2                                       |                      |                                |   |       |
|                     | ש ב  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to                                | o (or as a conseq                                     | juence of):                             |                       |   |                                  |   |                      |                                |   |       |
|                     | ecute<br>and<br>trans  | Examin         | Cause (Disease or injury that initiated events resulting in death) Last            | C                                     | /   |   |                       |   |                                  |   |                      | <u></u>                        |   | - 1   |
| 8760,               | cate be executed<br>physician and<br>the burial-transit  | E E            |  | Due to                                | o (or as a conseq                                     | (uence or):                             |                       |   |                                  |   |                      |                                |   |       |
|                     | physicate the last   | dicai          |  | d                                     |   |   |                       |   |                                  |   |                      |                                |   |       |
| ×                   | death certiff e attending id for use as  | /Me            | IF FEMALE:   | 23c. If ves. or                       | utcome of pregna                                      | ancv                                    |                       |   |                                  |   |                      | 20d D-1/ d-                    | 6   |       |
| Box                 | atter  | ciar           | 23b. Was decedent pregnant in the past 12 months?                                  | 1 Live                                | birth 2 ☐ Feta<br>nant at time of c                   | ıl death 3 □                            | Ectopic  <br>Other (s | regnancy                                |                                  |   |                      | 23d. Date of de<br>Month       | Day Year                                      |       |
| o.                  | at the death certific<br>I by the attending patached for use as  | Physician/M    | 1 □ Yes 2 □ No<br>9 □ Unknown  | 9□ Unki                               |   |   | , , , , , , , , , ,   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                                  |   |                      |                                |   |       |
| ر.<br>ت             | The law requires that the site hes been signed by the page 2 should be detached.   | by P           | Part II. Other significant conditi   | ons contributing to                   | death but not res                                     | ulting in the ur                        | nderlying             | cause given i                           | n Part I.                        | 23e. Did                                | tobacco u            | se contribute l                | o the cause of death                          | ?     |
| ğ                   | w require<br>been sig<br>should b  |                | may perte  | 15101                                 | , D19   | Det                                     | 25                    |   |                                  | 1 🗆                                     | Yes 2                | □No 3□P                        | robably 4 Unknown                             | nwc   |
| ပ္တ                 | s bee  | je             | Coronard   | 1 arte                                | M d   | 1509                                    | SE                    | •                                       |                                  | 24a. Was                                |                      | 24b. Were a                    | utopsy findings availa<br>completion of cause | able  |
| Vital Records,      | ding Physician: The lav<br>h.<br>Affer this certificete hes<br>funeral director, page 2  | Completed      | autopsy prior to comperformed? death?  |                                       |   |   |                       |   |                                  |   |                      | completion of cause<br>s 2□ No | of  |       |
|                     |  | Bec            | 25. Was case referred to medica  | t                                     |   |   |                       | 26                                      | S. Place of De                   | 1 ☐ Yes<br>ath (Check only              |                      | 10.10                          | S 2   NO                                      |       |
| >                   | Attending Physician: r death. sector: After this certific by the funeral director.   | To             | examiner?<br>1 ☐ Yes 2 ☑ No  | Hospital:                             | Inpatient 2   | ER/Outpatien                            | t 3□ C                | OA Other:                               | 4 Nursing H                      | Home 5 ☐ Res                            | dence                | 6 □Other (Spe                  | ecify)  |       |
| 0                   | ng Pt<br>fter tt<br>neral  |                | 27. Manner of Death 1 Natural 5 □ Pendir   | 28a. Date                             | of Injury<br>nth, Day Year)                           | 28b. Time of<br>Injury                  |                       | 28c. Injury at<br>Work?                 |                                  | 28d. Describe                           | how injur            | y occurred                     |   |       |
| 000                 | eath.<br>or: A<br>the fu   | cati           | 2 ☐ Accident investi   | gation                                |   |   | М                     |   | 2 🗆 No                           |   |                      |                                |   |       |
| Division of         | fier d<br>irect<br>n by  | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ                                       | nined   200. Flac                     | e of Injury - At he<br>ding, etc. (Specif             | ome, farm, stre<br>ly)                  | eet, facto            | ry, office                              |                                  | 28f. Location (<br>City or To           |                      |                                | ural Route Number,                            |       |
|                     | urs al   |                | 20 2   |                                       |   |   |                       |   |                                  |   |                      |                                |   |       |
|                     | To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur  | Medical        | 29a. Certifier 1 Certifyir (Check only one)  | ng Physician: To the Examiner: On the | ie best of my kno<br>basis of examina<br>nner stated. | wiedge, death<br>tion and/or inv        | occurre<br>estigatio  | d at the time, on, in my opinion        | date and place<br>on, death occu | e, and due to the<br>urred at the time, | cause(s)<br>date and | and manner a<br>place, and du  | s stated.<br>e to the cause(s)                |       |
|                     | To the<br>within 2<br>To the<br>complei  | Μe             | 29b. Signature and title of certifie   |                                       | or stated.  |   | 29                    | c. License nu                           | ımber                            |   | 29d. Dat             | te signed (Mon                 | th, Dey, Year)                                |       |
|                     | - s + ō  |                | SERVINA  | CWO. r                                | NN  |   | (                     | 000                                     | 5531                             | 14                                      | 1.0                  | . 12                           | 2000  |       |
| 10                  | (14)   |                | 30. Name and address of person   | who completed cau                     | ise of death (Item                                    | n 23a) (Type. I                         | Print)                |   | <i></i>                          | 1                                       | 10                   | 1 3/2                          | 0000  |       |
| 14                  |  |                | SYLVESTER O  | 16NICW                                | 0. 6161   | ONO                                     | in 10                 | hic RL                                  | ), STE                           | 507 1                                   | DXO                  | 1 /thu,                        | mp 207  | 45    |
|                     | Sta<br>Registra  |                | 31. Date filed (Month, Day, Year)  | 2005                                  | Registrar's Signa                                     | ture                                    | Les .                 |   |                                  |   |                      |                                |   |       |

|                |  |  | 1 - For<br>State<br>Registrar   | State of N                                     | Marylan                     |                                 | artment of H                                   |                             |                         | ental Hy                          | giene<br>Rog. No.                       | 2006                          | . 423                            | 3 1 1         |
|----------------|--|--|---|--|-----------------------------|---------------------------------|--|-----------------------------|-------------------------|-----------------------------------|---|-------------------------------|----------------------------------|---------------|
|                | Physici  | an   | 1. Decedent's Name (First, Middle,  |  |                             |                                 |  |                             |                         | 2. Date of De<br>Month<br>Decemb  | ath<br>Day                              | Yea                           | 3. Time of                       |               |
|                | /Medic<br>Examin   | al   | Glen Clifton L  4a. Facility Name (If not institution, c  |  | ar)                         |                                 | 4b. City, Town, or                             | Location o                  | of Death                | Decemb                            |   | 5, 200<br>County of De        |                                  | 5 A M         |
|                | Examili  | er   | 11201 Buckwood L  |  | ,                           |                                 | Rockville                                      |                             | or obdur                |                                   |   | ntgome                        |                                  |               |
|                | Funeral  |  |   | 5. Sex 7. /<br>1 ★ M 2 ☐ F                     |                             | last birthday)                  | If Under 1 Year<br>Months Days                 | If Under                    | 24 Hrs.<br>Min.         | 8. Date of Bir<br>(Month, Da      | +h                                      | 0.0                           | Birthplace (State of Country)    | or Foreign    |
|                | Director   |  | 579-09-9759 Usual Residence of Decedent   | IALIM ZUF                                      | 8                           | 8 Yrs.                          |  |                             |                         | Mar 1,                            | 191                                     | 7 Was                         | hington,                         | , D.C.        |
|                | /land  |  | 10a. State 10b. County  |  | 10c. City                   | y, Town or Lo                   | ocation  |                             |                         |                                   |   |                               | 10d. Inside Ci                   | ity Limits    |
|                | Man<br>B-f sh  | tor  | Maryland Montgon  | nery   | Rock                        | ville                           |  |                             |                         |                                   |   |                               | 1 ☐ Yes                          | <b>⊉</b> ∑XNo |
|                | or 28  | Funeral Director   | 10e. Street and Number  |  |                             |                                 | 10f. Zip Code                                  | -                           | _                       |                                   | 10g. Citi                               | zen of What (                 | Country?                         |               |
|                | ath w  | ral  | 11201 Buckwood La   | T  |                             |                                 | 20852  |                             |                         |                                   | USA                                     |                               |                                  |               |
|                | ltams  | une  | 11. Marital Status  1  Never Married 2  Married   | 12. Was Deceder<br>Armed Forces                | s?                          | S. 13.                          | Was Decedent of His<br>f Yes, specify Cubar    | spanic Orio<br>n, Mexican   | gin? (Spe<br>), Puerto  | cify Yes or No<br>Rican, etc.)    | )-                                      | 14. Race - An<br>Black, Wh    | nerican Indian,<br>nite, etc.    |               |
| 920            | urs af   | by   | 3 ☐ Widowed 4 ☐ Divorced  | d 1 X Yes 2 If Yes, Give 1<br>Year or Dates    | ĮWII                        |                                 | 1 ☐ Yes 2 🏋 No                                 | Specify:                    |                         |                                   |   | Specify: Wh                   | nite                             |               |
| 21215-0036     | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Itams 23a or 28a-1 show<br>ha Madical Exeminer must be notitized at  | Completed  | 15. Decedent's<br>(Specify only highest of  |  |                             | 16a. Dece                       | dent's Usual Occupa<br>kind of work done d     | ition                       | t of working            | 10                                | 16b. Kir                                | nd of Busines                 |                                  |               |
| 21             | within ne.   | mple   | Elementary/Secondary (0-12)   | College (1-4o                                  | or 5+)                      | life.                           | DO NOT use retired)                            | )                           | 0 40110                 | <i>'</i> 9                        |   |                               |                                  |               |
| 2              | Hygie<br>thart<br>int, th  | Co   | 12<br>17. Father's Name (First, Middle, La  | ist)   |                             | Photog                          | grapher  | 18. Mothe                   | r's Name                | (First, Middle                    |   | spaper                        |                                  |               |
| an             | ld be<br>ental<br>ked o  | To Be  | Glen Clifton Lead   |  |                             |                                 |  |                             |                         | eagle                             | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | <i>Juntanio</i> )             |                                  |               |
| Maryland       | shou<br>and M<br>s mar<br>umat   | -  | 19a. Informant's Name/Relationship  |  |                             | 19b. Mailir                     | ng Address (Street a                           |                             |                         |                                   | er, City or                             | Town, State                   | , Zip Code)                      |               |
| Σ,             | and 2<br>saith<br>n 27 i   |  | Lillian Leach/wif   | Ēe   |                             |                                 | Buckwood                                       |                             | e Ro                    | ckville                           | , MD                                    | 20852                         | 2                                |               |
| Baltimore,     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant. The Medical Exact near Item could be recitified at ODGs. | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location  20c. Location |   |  |                             |                                 |  |                             |                         |                                   |   | cation - City o               | or Town, State                   |               |
| ξĦ             | t. Pag<br>rtment<br>rtant:   |  | ' 4 ☐ Donation 15 ☐ Other (Spe  | city)  |                             |                                 | ce Cremato                                     |                             |                         |                                   |   |                               | e, Maryla                        | and           |
| Bal            | permi<br>Depa<br>Impo<br>any i   |  | 21. Signature of Funeral Service Lic  | ensee /  |                             |                                 | name and Address<br>Oing Home                  |                             |                         |                                   |   |                               |                                  |               |
|                |  |  | 23a. Part1. Enter the disease, or co  | omplications that caus                         | ed the death                |                                 | everly L.<br>er the mode of dying              |                             |                         |                                   |   | rksvil                        | Approximate                      | θ             |
| 1              | Pnysician :  |  | shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition                          |  |                             |                                 |  |                             |                         |                                   |   |                               | Onset and D                      | Death         |
|                | /Medical   |  | resulting in death)   | a. Dyspha)<br>Due to (or a                     | as a consequ                | uence of):                      |  |                             |                         |                                   |   |                               | 3 month                          | as            |
|                | Examiner   | L  | Sequentially list conditions,   | ь. Progres                                     | ssive                       | Suprar                          | uclear Pa                                      | 1sey                        |                         |                                   |   |                               | 2 years                          | 5             |
|                | ted  | Examiner   | Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury | Due lo (or a                                   | as a consequ                | uence of):                      |  |                             |                         |                                   |   |                               |                                  |               |
|                | execun<br>n and<br>al-tra  | xar  | that initiated events<br>resulting in death) Last   | c.<br>Due to (or a                             | is a consequ                | uence of):                      |  |                             |                         |                                   |   |                               |                                  |               |
| 8760,          | death certificate be executed<br>e attending physician and<br>od for use as the burial-transit   | call   |   | d  |                             |                                 |  |                             |                         |                                   |   |                               |                                  |               |
| 9              | ntifica<br>ing ph  | Physician/Medical  | IF FEMALE:  |  |                             |                                 |  |                             |                         |                                   |   |                               |                                  |               |
| Вох            | that the death certific<br>ed by the attending p<br>detached for use as  | lan/l  | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcom                            | 2 Fetal                     | death 3                         | Ectopic pregnancy                              |                             |                         |                                   | 2                                       | 3d. Date of do                | ,                                | rear .        |
|                | he de<br>/ the a   | yslc   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant<br>9□Unknown                        |                             | eath 5∟                         | Other (specify)                                |                             |                         |                                   |   | Wiena                         | Juy                              | Jan           |
| P.0            | The law requires that the ate has been signed by the bage 2 should be detache  |  | Part II. Other significant conditions   | s contributing to death                        | but not resu                | ulting in the u                 | nderlying cause give                           | n in Part I.                |                         | 23e. Did t                        | obacco us                               | se contribute                 | to the cause of de               | eath?         |
| rds            | w requires<br>been sign<br>should be   | ed by  |   |  |                             |                                 |  |                             |                         | 101                               | ∕es 2√                                  | ]No 3□F                       | Probably 4 🗀 U                   | Inknown       |
| 000            | law requas been 2 should   | plet   |   |  |                             |                                 |  |                             |                         | 24a. Was                          |   |                               | autopsy findings a               |               |
| E E            |  | Completed  |   |  |                             |                                 |  |                             |                         |                                   | rmed?                                   | death?                        | '                                | 1036 01       |
| Vital Records, | Physician: Th<br>r this certificate<br>ral director, pag   | Be   | 25. Was case referred to medical examiner?  | Hospital:                                      |                             |                                 | Otho   |                             |                         | (Check only o                     |   |                               |                                  |               |
|                | 를 들고   | . To   | 1 ☐ Yes 2 ☐XNo 27. Manner of Death  | 28a. Date of In                                |                             | ER/Outpatien<br>28b. Time of    | t 3 DOA  | - 4 □ Nur<br>at             |                         | ne 5 XResid                       |   |                               | ecify)                           |               |
| ion            | Attending Ph<br>r death.<br>actor: After th<br>by the funeral  | atlor  | 1 Natural 5 Pending 2 Accident investigat   | (Month, D                                      | Jay Year)                   | Injury                          | 28c. Injury<br>Work'<br>M 1 ☐ Y                | ?<br>es 2 □ N               |                         |                                   | ,,                                      |                               |                                  |               |
| Division of    | or Attencatter death<br>Diractor:<br>in by the   | Certification:   | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   | ad 289. Place of I                             | njury - At hosetc. (Specify | me, farm, str                   | eet, factory, office                           |                             | 2                       | 8f. Location (S<br>City or Tox    |   | Number or F                   | Rural Route Numb                 | ber,          |
| Ö              | ital or<br>rrs aft<br>ral Di   |  |   |  |                             | 7/6                             |  |                             |                         |                                   |   |                               |                                  |               |
|                | To tha Hospital or At within 24 hours after or To tha Funaral Dirac completely filled in by  | edical   | 29a. Certifier 1 XCertifying I (Check only one) 2 Medical Ex  | Physician: To the best<br>aminer: On the basis | of examinat                 | wledge, death<br>ion and/or inv | occurred at the time<br>restigation, in my opi | e, date and<br>inion, deatl | d place, a<br>h occurre | nd due to the d<br>d at the time, | cause(s) a<br>date and                  | and manner a<br>place, and du | as stated.<br>ie to the cause(s) | )             |
|                | To tha within 2 To tha complet   | Med  | 29b. Signature and title of certifier   | and manner s                                   | stated.                     |                                 | 29c. License                                   | number                      |                         |                                   | 29d. Date                               | signed (Mor                   | nth, Day, Year)                  |               |
| 2              |  |  | Jo. (1)   | Kennedan                                       | imp                         | 0                               | D21115   | 5                           |                         |                                   |   |                               | , 2005                           |               |
| 1.00           | 5,0+   |  | 30. Name and address of person wh   | no completed cause of                          | death (Item                 | 23a) (Type,                     |  |                             |                         |                                   |   |                               | ,                                |               |
|                |  |  | Lee R. Penningtor   |  | · · · · · · · ·             |                                 | Rd. Suit                                       | e 100                       | 0 Bet                   | hesda,                            | MD                                      | 20817                         |                                  |               |
|                | Sta<br>Registr   |  | 31. Date filed (Month Day Year) 6   | 2005 32. Pobis                                 | strar's Signat              | ure /                           | bark   |                             |                         |                                   |   |                               |                                  |               |

|                     |  |                  | 1 - For<br>State<br>Registrar   |  | Marylar                                       | nd / Dep                         |                            | t of H                   | lealth a                   | and N           | lental Hy                         |                        | nn                     | 5         | 4231                                  | 12         |
|---------------------|--|------------------|---|--|---|----------------------------------|----------------------------|--------------------------|----------------------------|-----------------|-----------------------------------|------------------------|------------------------|-----------|---------------------------------------|------------|
| 18                  | Dhusia   |                  | 1. Decedent's Name (First, Middle   |  |   |                                  |                            |                          |                            |                 | 2. Date of Dea                    | ath<br>Day             | , ,                    | Year      | 3. Time of De                         | ath        |
|                     | Physic<br>/Medi  |                  | Elizabeth   | S.   | Li  | lley                             |                            |                          |                            |                 | Decemb                            |                        |                        |           | 1959                                  | М          |
|                     | Exami  |                  | 4a. Facility Name (If not institution   | -  | -   |                                  | 4b. City,                  | Town, or                 | Location of                | of Death        | <del>'</del>                      |                        | County o               | f Death   |                                       |            |
|                     |  |                  | Anne Arundel 1  | Medical Ce   | nter  |                                  | An:                        | napo                     | 1is                        |                 |                                   | A                      | nne                    | Arui      | nde1                                  |            |
| 1                   | Funeral  |                  | 5. Social Security Number   |  | 7. Age (In yrs.                               | last birthday)                   | If Under<br>Months         | 1 Year<br>Days           | If Under<br>Hours          | 24 Hrs.<br>Min. | 8. Date of Birt<br>(Month, Da     | h                      |                        |           | place (State or Fi                    | oreign     |
|                     | Director   |                  | 217-12-8706   | 1 □ M 2 <b>X</b> XF  | 84  | Yrs.                             | WOTHING                    | Days                     | riours                     | tytut.          | Sept. 1                           |                        | 921                    | Mary      | land                                  |            |
|                     | p ,  | 1                | Usual Residence of Decedent   |  | 140 0   | -                                |                            |                          |                            |                 |                                   |                        |                        |           |                                       |            |
|                     | aryla  | -                | 10a. State 10b. County  |  | 10c. Cit                                      | ty, Town or Lo                   | ocation                    |                          |                            |                 |                                   |                        |                        | 1         | 0d. Inside City L                     |            |
|                     | Ba-f   | cto              | MD Anne   | Arundel  | Cro   | ownsvi                           | 11e                        |                          |                            |                 |                                   |                        |                        |           | 1 ☐ Yes 2                             | XNo        |
|                     | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | Funeral Director | 10e. Street and Number  |  |   |                                  | 10f. Zip                   | Code                     |                            |                 |                                   | 10g. Citi:             | zen of Wh              | nat Cour  | ntry?                                 |            |
|                     | 23a  | 2                | 535 Palisades 1   | 31vd.  |   |                                  |                            |                          |                            |                 |                                   | US                     | A                      |           |                                       |            |
|                     | r dea  | nei              | 11. Marital Status  | 12. Was Deced  | dent Ever in U                                | .S. 13.                          | Was Deced                  | dent of Hi               | ispanic Ori                | gin? (Spe       | ecify Yes or No-<br>Rican, etc.)  |                        | 14. Race               |           | an Indian,                            |            |
| 9                   | afte<br>or it  | 五                | 1 Never Married 2 Marr  |  | XX No   |                                  | 1 Yes                      | _                        | Specify:                   | ,, , , ,        | rtioan, oto.,                     |                        |                        | White,    |                                       |            |
| 9                   | urai',   | d by             | 3 X Widowed 4 □ Divorced  | Year or Da   | tes:  |                                  | 10103                      | 2 Q 140                  | эреспу.                    |                 |                                   |                        | Specify:               | wr        | ite                                   |            |
| 5-                  | be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or Itame 23a or 28a-f show event, the Madical Examinat must be notified at | Completed        | 15. Deceden<br>(Specify only highes   | 's Education   |   |                                  | dent's Usua<br>kind of wor |                          |                            | t of worki      | ma                                | 16b. Kir               | nd of Busi             | iness/Ind | dustry                                |            |
| 2                   | ithin<br>Ban   | ldu              | Elementary/Secondary (0-12)   | College (1-  | 4or 5+)                                       | life.                            | DO NOT us                  | se retired               | )                          |                 |                                   |                        |                        |           |                                       |            |
| 7                   | ygier<br>ygier<br>t,   | ပိ               | 12  |  |   | Cler                             | ζ                          |                          |                            |                 |                                   | Tel                    | epho                   | ne C      | Company                               |            |
| pu                  | tal H<br>d ott   | Be               | 17. Father's Name (First, Middle,   | Last)  |   |                                  |                            | Ì                        | 18. Mothe                  | er's Name       | (First, Middle,                   | Maiden                 | Sum <b>am</b> e)       | )         |                                       |            |
| Via                 | Ment<br>Ment<br>arke   | 2                | Samuel Swann  |  |   |                                  |                            |                          | May                        | Shi             | pley                              |                        |                        |           |                                       |            |
| Maryland 21215-0036 | s 1 and 2 should be filed within<br>f Health and Mental Hygiene.<br>Item 27 is marked other than "<br>other traumatic event, I'm Mar                                     |                  | 19a. Informant's Name/Relations   | nip (Type, Print)  |   | 19b. Maili                       | ng Address                 | (Street a                | and Numbe                  | or Or Rura      | al Route Numbe                    | r, City or             | Town, S                | tate, Zip | Code)                                 |            |
|                     | 5 = 2 =  |                  | Betty Hazell (I   | aughter)   |   | 535 1                            | Palisa                     | ades                     | B <sub>1</sub> vd          | . , C           | rownsvi                           | 11e.                   | MD                     | 2103      | 2                                     |            |
| ore.                | of Heal  |                  | 20a. Method of Disposition<br>1 ☐ Burial 2 💆 Cremation  |  | 20b. F  | Place of Dispo                   | sition (Nan                | ne of                    |                            |                 | Date                              |                        | cation - C             |           |                                       |            |
| Ĕ                   | Page<br>net o<br>nt: if  |                  | 4 □ Donation 5 □ Other (S   |  | tate  | ro Cre                           | ,                          |                          | 1                          | 2-13            | -2005                             | Rol+                   | imor                   | o M       | T                                     |            |
| Baltimore,          | permit. Pages Department of I importent: If ite any injury or of   |                  | 21. Signature of Funeral Service  | Licen <b>a</b> e ,   |   |                                  | 2. Name an                 | d Addres                 | s of Facilit               | V               |                                   |                        | TIMOL                  | e, 11     | ש                                     |            |
| m                   | e e ii o   |                  | 175- 3  | · Clyn-  | ~   |                                  | Harde                      | esty                     | Fune:                      | ral :           | Home, P<br>, Annap                | .A.                    | MD                     | 21/       | 0.1                                   |            |
|                     |  |                  | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that ca                                      | used the deat                                 | h. Do not ent                    | er the mode                | e of dying               | g, such as                 | cardiac c       | r respiratory ar                  | rest.                  | • MD                   | 214       | Approximate                           |            |
|                     | Physician<br>/Medical<br>Examiner  |                  | Immediate Cause (Final disease or condition resulting in death)   | a  | Tas conseq                                    | uence of):                       | a\                         | I                        | nfa                        | ٠.٠             |                                   |                        |                        |           | Interval Betwee<br>Onset and Dea      | ih         |
| 8760,               | The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit       | Ical Examiner    | Sequentially list conditions, a.y. each by to min diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c  | r as a conseq                                 | ·                                |                            |                          |                            |                 |                                   |                        |                        |           |                                       |            |
| 9                   | ificate<br>g phys<br>as the  |                  |   | 0.   |   |                                  |                            |                          |                            |                 |                                   |                        |                        |           |                                       |            |
| O. Box              | that the death certifica<br>led by the attending ph<br>detached for use as th  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   |  | th 2 ☐ Feta<br>nt at time of d                | Ideath 3                         | Ectopic pre<br>Other (spe  |                          |                            |                 |                                   | 2                      | 3d. Date of Month      |           | ry<br>Day Year                        |            |
| ۹.                  | s that   | by Pi            | Part II. Other significant condition  | ns contributing to dea                                     | th but not resi                               | ulting in the u                  | nderlying ca               | ause give                | n in Part I.               |                 | 23e. Did to                       | bacco us               | se contrib             | ute to th | e cause of death                      | 1?         |
| ğ                   | quires<br>n sign   | D D              |   |  |   |                                  |                            |                          |                            |                 | 1 🗆 Y                             | es 2                   | No 3                   | ☐ Proba   | ably 4 Unkr                           | iown       |
| Records,            | w requir<br>been si<br>should  | Completed        |   |  |   |                                  |                            |                          |                            |                 | 24a. Was a                        |                        | 24h 14/c               | · ·       | au findinas aus                       | labl-      |
| Вe                  | The lav  | E P              |   |  |   |                                  |                            |                          |                            |                 | autops                            | SV                     | pric                   | or to con | sy findings avai<br>opletion of cause | able<br>of |
| ā                   |  |                  | or was a second   |  |   |                                  |                            |                          |                            |                 |                                   | 2 2 No                 |                        | Yes       | 2□ No                                 |            |
| Vital               | sician: Certifical rector, p   | Be (             | 25. Was case referred to medical examiner?  | Hospital:  |   |                                  |                            | Othe                     | ~                          |                 | Check only or                     |                        |                        |           |                                       | _          |
| ō                   | Physician:<br>r this certificatal director, p  | . T              | 1 ☐ Yes 2 ☑ No 27. Manner of Death  | 1 lnj  |   | ER/Outpatien<br>28b. Time of     |                            |                          | 4 🗆 1901                   |                 | ne 5 Reside                       |                        |                        |           | )                                     |            |
| L<br>C              | ding<br>After  | E I              | 1 Natural 5 ☐ Pending   |  | Day Year)                                     | Injury                           | M                          | Work                     | ?                          |                 | 28d. Describe h                   | ow injury              | occurred               |           |                                       |            |
| <u>S</u>            | Attending<br>r death.<br>actor: After<br>by the fune   | Ica              | 2 Accident investig 3 Suicide 6 Could n   | ot be 200 Place of   | d Injune At he                                | ma form at                       |                            |                          | 'es 2 □ N                  |                 | 004 1 41 (0                       | 44                     |                        |           |                                       |            |
| É                   | al or Attendii<br>after death.<br>I Director: A<br>d in by the fu  | Certification:   | 4 Homicide determi  | ned building   | of Injury - At ho<br>g, etc. <i>(Specif</i> y | /)                               | eet, ractory,              | , опісе                  |                            | -               | 28f. Location (Si<br>City or Town |                        | Number                 | or Hurai  | Houle Number,                         |            |
|                     | To the Hospital or Attending Physician: Within 24 hours after death. Within 72 hours after death. Completely filled in by the funeral director.                          | ledical Co       | 29a. Certifier (Check only one)  Certifying  (Check only one)   | g Physician: To the b<br>Examiner: On the bas<br>and manne | is of examinal                                | wledge, death<br>tion and/or inv | occurred a                 | at the time<br>in my op- | e, date and<br>inion, deat | d place, a      | and due to the co                 | ause(s) a<br>ate and p | and mann<br>place, and | er as sta | ated.<br>the cause(s)                 |            |
|                     | o th<br>o th<br>ompl   | Me               | 29b. Signature and title of certifier   | 22 (114.1116   |   |                                  | 29c.                       | License                  | number                     |                 | 2                                 | 9d. Date               | signed (/              | Month. [  | Day, Year)                            |            |
|                     | r > ⊢ ō  |                  | 1/19  |  |   |                                  |                            | 70                       | 611                        | 2-              | 7                                 | , ,                    | ./.                    | , /       | - 6                                   |            |
| •                   |  |                  | 30 Name of the State of   | A  |   | 00.10                            | D-1-0 -                    | 7                        | ١١ ر                       | ر               |                                   | 12                     | -/ (2                  | -/ (      | 25                                    |            |
|                     |  |                  | 30. Name and address of person v  |  | or death (item                                | ZNa) (Type,                      | Print) 1                   |                          | 11                         | r               | 1 0                               | 1                      |                        |           |                                       |            |
|                     | Sta  | to               | 31. Date filed (Month, Day, Year)   | 32. Rec  | istrar's Signa                                | ture                             | 2 1                        | IVUN                     | de /                       |                 | 15 91                             | (2)                    |                        | en        | 1e                                    |            |
| £                   | Registr  |                  | DEC 1   | 4 2005   |   | M                                | A                          | d :                      | an wind                    | m market on     |                                   | ~                      |                        |           |                                       |            |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items 10d 19a 20b c per inf 9853 3-20-06 vt.

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 525 p M Kenneth C. Loeb 14 12 2005 Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Regional Medical Center Salisbun Teninsula Wicomico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2-23-1940 Social Security Number 6. Sex | 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min 65 413-62-2126 Michigan Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits TATTES 2 No Delaware Sussex Ocean View 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Balsa Street 19970 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: 58-62 1 ☐ Yes 2 No Specify White Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Title Processor Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Chris Loeb Freida Jones 19a. Interest lane/Relationship (Type Priend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louella Wright/ Sister 27 Balsa Street, Ocean View, DE. 19970 20b. Plan of Bisposfior Heaven cemetery, cremato Dagsboro City or Town, State 20a. Method of Disposition Date 2 Crems 1 X Burial 3 Removal from State 4 □ Donation 5 ☑ Oth (Specify) -Millsbore, Delaware 12-19-05 21. Signatury of Puneral Service Prensee 22. Name and Address of Facility Melson Funeral Services, Ltd West Ave, Ocean View, Delaware. ase of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on each line. 23a. Part . Enter the disease shock or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 cardin Iweek Due to (or as a consequence of): wonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated acts) Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760 1 Kenneth

The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar certificete has or Attending Physicien: this iers! Dirsctor: After the filled in by the funeral death. within 24 hours after To the Funers! Dira \$ \$

**Physician** 

/Medical

Director

Completed by Funeral

Be

2

Examiner

Completed by Physician/Medical

Be

Certification; To

Medical

29a. Certifier

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if item 27 is marked other then \*neturet', or itams 23a or 28s-1 ehow any injury or other treumatic event, the Madical Examination must be notified at once.

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0036

H. 12t State Registrar

Julian 413 DEC 1 6 31. Date filed (Month, 2005

29b. Signature and interest certifier

30. Na e a d address of person who completed cause of death (Item 23a) (Type, Print) 201 MD

32 Pegistry's Signature

D41813

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

December 14, 2005

Pine Bluff Rd. Salisbury,

05-8291 B.K.S TOND

## Please Type or Print in Black Indelible Ink Fraure All Copies Are Legible

| DRI                 | EA M. LO  | ONI                 | For   | State of Maryla  | nd / D               | epa             | artmer                  | nt of H                                  | ealth                    | and M                  | -                                  |                          | _   | 42344  |  |
|---------------------|---|---------------------|---|--|----------------------|-----------------|-------------------------|--|--------------------------|------------------------|------------------------------------|--------------------------|---|--|--|
|                     |   |                     | State<br>Registrar  |  |                      | Cer             | tifical                 | te of L                                  | Death                    | 1                      |                                    | Reg. N                   | 6. 000  |  |  |
|                     | Physici   | an                  | Decedent's Name (First, Middle, La.   | st)  |                      |                 |                         |  |                          |                        | 2. Date of Month DEC.              |                          | <sup>ay</sup> 2005 <sup>Year</sup>              | 3. Time of Death                               |  |
|                     | /Media  |                     | TONDREA MAUREEN   |  |                      |                 |                         |  |                          |                        | DEC.                               |                          |   | 8:14 P M                                       |  |
|                     | Examin  | er                  | 4a. Facility Name (If not institution, giv.<br>PRINCE GEORGES Ho  |  | R                    |                 |                         | , Town, or<br>EVERL                      |                          | of Death               | 4c. County of Death PRINCE GEORGES |                          |   |  |  |
|                     | Funeral   |                     | Social Security Number     6. S   | ex 7. Age (In yr   |                      |                 | If Unde<br>Months       | r 1 Year<br>Days                         | If Unde<br>Hours         | r 24 Hrs.<br>Min.      | 8. Date of (Month,                 | Day, Year                | r) 9. Birth<br>Cor                              | nplace (State or Foreign untry)                |  |
|                     | Director  |                     | 577 96 1960   | M AND  | 41`                  | rs.             |                         |  |                          |                        | APR.                               | 12, 1                    | 964 MAR   | YLAND  |  |
|                     | and *   |                     | Usual Residence of Decedent  10a, State 10b, County   | . 10c. 0   | City, Town           | or Lo           | cation                  |  |                          |                        |                                    |                          |   | 10d. Inside City Limits                        |  |
|                     | e Maryl   | ctor                | MD PRINCE G   | EORGES SU  | ITLA                 | ND              |                         |  |                          |                        |                                    |                          |   | XXYes 2□No                                     |  |
|                     | with th   | Dire                | 10e. Street and Number  | art m  |                      |                 | 10f. Zi                 | p Code                                   | 716                      |                        |                                    |                          | citizen of What Cor                             |  |  |
|                     | s 23s   | rai                 | 2224 HOUSTON STR  |  | 11.0                 | 10.1            | M D                     |  | 746                      |                        | - d . V                            |                          | UNITED ST                                       |  |  |
| Maryland 21215-0036 | y within 72 hours after death with the Maryland<br>liene.<br>r than "natural", or items 23a or 28a-f show<br>the Medical Examble motified at  | by Funeral Director | 11. Marital Status  XiX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever in Armed Forces?  1 □ Yes ※ No If Yes, Give Year or Dates: | 0.5.                 |                 |                         | Cify Cubai                               |                          |                        | ecify Yes or<br>Rican, etc.)       | NO-                      | 14. Race - Amer<br>Black, White<br>Specify: BLA | , etc.   |  |
| 20                  | 72 ho   | ted                 | 15. Decedent's E  | ducation   | 16a.                 | Deced           | dent's Usu              | ial Occupa<br>ork done d<br>use retired, | ation                    | st of work             | ina                                | 16b.                     | Kind of Business/l                              | ndustry  |  |
| 2                   | within ene.   | Completed           | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                      | life. I         | DO NOT I                | se retired,                              | )                        | 0. 0                   | <b>.</b>                           |                          |   |  |  |
| 2                   |   | Š                   |   | 2 YRS.   | AI                   | DMI             | NIST                    | RATIV                                    |                          |                        |                                    |                          |   | IS BUREAU                                      |  |
| Ē                   | 2 2 5 2 E   | Be                  | 17. Father's Name (First, Middle, Last,   | )  |                      |                 |                         |  |                          |                        |                                    | die, Maide               | n Sumame)                                       |  |  |
| 3                   | should be<br>nd Mental<br>marked o  | ٦                   | ERIC G. LONDON  19a, Informant's Name/Relationship (  | Toron Orient   | 405                  | N.A = 101=      |                         | - (044                                   |                          |                        | BELL                               | 0:                       |   | :- O- 1-1                                      |  |
| Mai                 | 2 6 9 3   | 1. 3                |   |  | 1                    |                 |                         |  |                          |                        |                                    |                          | or Town, State, Z                               |  |  |
|                     | s 1 and 2<br>f Health<br>item 27<br>other tre   |                     | MALVINA SMITH / 1 20a. Method of Disposition  | MOTHER 206   |                      |                 |                         | OYLVA<br>ime of<br>other place           |                          |                        | #203<br>Date                       | -                        | Location - City or 1                            | MD 20747                                       |  |
| ğ                   | e = 5   |                     | XXBurial 2 Cremation 3  | Jemovar nom State  |                      |                 |                         |  |                          | 10/1                   |                                    |                          |   |  |  |
| Baltimore,          | permit. Par<br>Departmen<br>Important:<br>eny injury<br>once.   |                     | 4 □Donation 5 □Other (Specifical Structure of Fure at Service Licer   |  | LNCOL                | 1               |                         | LIAL (<br>nd Addres                      |                          |                        | 5/2005                             | St                       | JITLAND,  | MD   |  |
| Ba                  | permit. Departmitimporta eny inju   |                     | 1 7 9   | W D Q Q  |                      |                 | MARSI                   | IALL'                                    | S FU                     | NERAI                  |                                    |                          | MARYLAND,                                       |  |  |
|                     | _   | -                   | 23a. Part1. Enter the disease, or com<br>shock or heart failure. List only  | plications that caused the de  | ath. Do r            |                 |                         | SUIT<br>de of dying                      |                          |                        | or respirator                      | LTLAN<br>arrest,         | ND, MD 20                                       | Approximate<br>Interval Between                |  |
|                     | Dhusisian   | g 17                | Immediate Cause (Final  | MUMPLE   |                      |                 |                         |  |                          |                        |                                    |                          |   | Onset and Death                                |  |
|                     | Physician /Medical  |                     | disease or condition resulting in death)  | aDue to (or as a cons  | _                    |                 | رخار                    |  |                          |                        |                                    |                          |   |  |  |
|                     | Examiner  | H                   |   |  |                      | ,.              |                         |  |                          |                        |                                    |                          |   |  |  |
|                     |   | ĕ                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or as a sone  | equanes o            | x():            |                         |  |                          |                        |                                    |                          |   |  |  |
|                     | ate be executed<br>tysician and<br>he burial-transit  | Examiner            | Cause (Disease or injury that initiated events  | C.   |                      |                 |                         |  |                          |                        |                                    |                          |   |  |  |
| oʻ                  | an an<br>rial-tr  |                     | resulting in death) Last  | Due to (or as a cons-  | equence              | of):            |                         | -  |                          |                        |                                    |                          |   |  |  |
| 1760,               | ite be<br>iysici<br>ie bu   | cal                 |   | _ d.   |                      |                 |                         |  |                          |                        |                                    |                          |   |  |  |
| . 68                | ng ph   | Jed                 | IF FEMALE:  |  |                      |                 |                         |  |                          |                        |                                    |                          |   |  |  |
| Вох                 | leath certificat<br>attending phy<br>I for use as the   | Physician/Med       | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of preg<br>1☐Live birth 2☐Fe                                |                      | 3[              | Ectopic p               | oregnancy                                |                          |                        |                                    | 1                        | 23d. Date of delivered Month                    | very<br>Day Year                               |  |
|                     | at the dea<br>by the at<br>tached fo  | sici                | 1 Ves 2 No  | 4□Pregnant at time of<br>9□Unknown   | death                | 5 □             | Other (s                | pecify)                                  |                          |                        |                                    | -                        | WOILL   | Day 1 dai                                      |  |
| P.0                 | that the  |                     | Part II. Other significant conditions of  | contribution to death but not r  | esultina in          | the u           | nderlying               | Cance dive                               | an in Part               | 1                      | 23a Di                             | id tobacco               | use contribute to                               | the cause of death?                            |  |
| rds,                | w requires the been signed should be compared to the contract of the contract | ed by               | Tarrii. Ottor significant contains o  |  |                      |                 | nderlying               | oause give                               | or in r are              |                        |                                    |                          | 1/  | bably 4 Unknown                                |  |
| of Vital Records,   | The lay   | Completed           |   |  |                      |                 |                         |  |                          |                        | 24a. W<br>au<br>pe                 | itopsy<br>informed?      | prior to c<br>death?                            | copsy findings available ompletion of cause of |  |
| ita                 | iiclan: Th<br>certificate<br>rector, pag  | BeC                 | 25. Was case referred to medical examiner?  |  |                      |                 |                         |  | 26. Plac                 | e of Deat              | h (Check on                        |                          |   |  |  |
| <b>Y</b>            | hysic<br>this ce<br>al direc  | 5                   | tv Yes 2 □ No   | Hospital: 1 Inpatient 2  | <b>∑</b> ER/Ou       | patien          | t 3□ D                  | OA Othe                                  | 9r: 4 □ N                | lursing Ho             | me 5 R                             | esidence                 | 6 ☐Other (Spec                                  | afy)   |  |
|                     | ding Ph<br>h.<br>After th<br>funeral  |                     | 27. Manner of Death 1 □ Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day Year)   |                      | ime of<br>ijury |                         | 28c. Injury<br>Work                      | at                       |                        | •                                  | 9.                       | ury occurred                                    |  |  |
| Sio                 | Attending Physiclan: r death. ector: After this certifics by the funeral director.  | cati                | 2 Accident investigatio   | . / - /  | 17                   | :16             | M                       | 101                                      | Yes 2                    | No                     |                                    |                          | STRUCK  | <u>'                                    </u>   |  |
| Division            | i or Attu<br>after de<br>Directu  | Certification:      | 3 Suicide 6 Could not be determined   |  | home, fa             | m, str          | eet, factor             | ry, office                               |                          |                        | City or                            | Found Sta                | and Number or Ru<br>te)                         |  |  |
|                     | oital (<br>urs al<br>ural D   |                     |   | RODOW  | -                    |                 |                         |  |                          |                        |                                    |                          |   | AMD P.4 6MD                                    |  |
|                     | the Hospital or Attention 24 hours after death the Funeral Director:  | Medical             | 29a. Certifier 1 Certifying Pl<br>(Check only 2 Medical Example)  | nysician: To the best of my k  | now ge<br>nation and | death<br>Vor in | occurred<br>vestigation | at the tim<br>n, in my op                | ie, date a<br>pinion, de | nd place,<br>ath occur | and due to to<br>red at the time   | he cause(<br>ne, date ar | s) and manner as<br>nd place, and due           | stated.<br>to the cause(s)                     |  |
|                     | thin 24 ho<br>the Fun<br>mpletely   | Med                 | 29b. Signature and title of certifier   | and manner stated.   |                      |                 | 29                      | c. License                               | number                   |                        |                                    | 29d. D                   | ate signed (Month                               | . Dav. Year)                                   |  |

1 Certifying Physician: To the best of my know ge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

athymate

O.C.M.E

DEC. 10, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE, MARYLAND 21201 MARYDRAM

State Registrar

31. Date filed (Month, Day, Year)

DEC 1 3 2005



| Certificate | of | Death  |
|-------------|----|--------|
| Certificate | UI | Dealli |

| Physician |  |
|-----------|--|
| /Medical  |  |
| Examiner  |  |
|           |  |

1. Decedent's Name (First, Middle, Last)

LANDIS

2. Date of Death

DECEMBER 12 2005

3. Time of Death 6:30  $\mathbf{P}^{\mathsf{M}}$ 

PATRICIA Ε. 4a. Facility Name (If not institution, give street and number,

4b. City, Town, or Location of Death

4c. County of Death PRINCE GEORGE'S

**Funeral** Director

Baltimore, Maryland 21215-0036

**Physician** /Medical

**Examiner** 

burial-tran

the as

the attending physician and

signed by

peen

certificate

After

Director:

within 24 hours a

To the Hospital or Attending Physician:

pe

page 2

etely filled in by the funeral

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

217-34-0451 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-1 show any Injury or other traumatic event, Ite Madical Examinar many ones. Director by Funeral 11. Marital Status Completed Be

2

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

3827 SWANN ROAD 7. Age (In yrs. last birthday)

69

SUITLAND If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, JULY 13 1936

9. Birthplace (State or Foreign WASHINGTON, DC

10b. County

SUITLAND

10c. City, Town or Location

10d. Inside City Limits

1 XYes 2 No

10e. Street and Number

5. Social Security Number

PRINCE GEORGE'S

10f. Zip Code

10g. Citizen of What Country? U.S.A.

Specify.

3827 SWANN ROAD

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No

14. Race - American Indian, Black, White, etc.

1 Never Married 2 Married 3 Nidowed 4 Divorced

Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

20746

BLACK 16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4or 5+)

SECRETARY

GOVERNMENT

12th 17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame)

HARRY WENDELL THOMAS VERMELL

Specify:

**ADAMS** 

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

ROBYN JACKSON/DAUGHTER

20b. Place of Disposition (Name of cemetery, crematory or other place)

7000 MUIR DRIVE FORT WASHINGTON, MARYLAND 20744 Date 20c. Location - City or Town, State

20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

MT. OLIVET CEMETERY 12/17/2005

WASHINGTON, DC

\* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Junean Service License

22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| CARD | IORESP | IRATORY | ARREST |
|------|--------|---------|--------|
|      |        |         |        |

Due to (or as a consequence of):

### OVARIAN CANCER

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? Yes 2 No 26. Place of Death (Check only one)

25. Was case referred to medical Hospital: 1 ☐ Yes 2XNo Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending investigation 2 Accident 6 ☐ Could not be

determined

28c. Injury at Work? 28b. Time of 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 X Natural

3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number D27650

December 13, 2005

29d. Date signed (Month, Day, Year)

such mo lynthia lucus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CYNTHIA CRAWFORD-GREEN M.D. 6196 OXON HILL ROAD # 500 OXON HILL, MARYLAND 20745

State Registrar 31. Date filed (Month, Day, Year)

DEC 1 4 2005



|            |  |                  | State of Maryland / Departmen  1 - State Registrer Certificat  | it of Health  |                 |                                     | ne<br>2005                        | 42346                           |
|------------|--|------------------|--|---|-----------------|-------------------------------------|-----------------------------------|---------------------------------|
|            |  |                  | Decedent's Name (First, Middle, Last)  |   |                 | Date of Death                       |                                   | 3. Time of Death                |
|            | Physicia   |                  | Janet Elaine Miller  |   |                 | 12/10                               | /2005                             | 11:07P M                        |
|            | /Medic<br>Examin   |                  |  | Town, or Location                                   | of Death        |                                     | 4c. County of Death               |                                 |
|            | LXdillill  | Ŭ.               | Longview Nursing Home M  | anchest   | er              |                                     | Carroll                           |                                 |
|            | Funeral  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months  | r 1 Year If Unde                                    | er 24 Hrs. 8    | Date of Birth<br>(Month, Day, Y     | ear)   Coi                        | nplace (State or Foreign untry) |
|            | Director   |                  | 219-20-2361 15 78 Yrs.   |   |                 | 01-16-                              | 1927Wash                          | ington DC                       |
|            | pu 💌   | -                | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location   |   |                 |                                     |                                   | 10d. Inside City Limits         |
|            | shor   | ä                |  |   |                 |                                     |                                   | 1√2 Yes 2 □ No                  |
|            | the N  | ect              | MD Carroll Hampstead  10e. Street and Number 10f. Zig  | Code  |                 | 100                                 | . Citizen of What Co              | untry?                          |
| :          | with<br>a or   | ă                | 4211 Hillcrest Avenue  | 21074   | i               |                                     | USA                               | ,                               |
|            | eath   | Funeral Director |  | dent of Hispanic O<br>cify Cuban, Mexica            |                 | y Yes or No-                        | 14. Race - Amer                   |                                 |
|            | fter d   | Fun              | 1 □ Never Married 2 □ Married 1 □ Yes 2√2 No   |   |                 | can, etc.)                          | Black, White                      | o, etc.                         |
| ဗ္ဗ        | urs a  | þ                | 3 ☑ Widowed 4 □ Divorced If Yes, Give 1 □ Yes  | <b>X</b> □ No Specify                               | y:<br>          |                                     | Specify: Wh                       | nite                            |
| 21215-0036 | within 72 hours after death with the Maryland<br>ene.<br>then "neturel", or items 23a or 28e-f show<br>the Modical Examitter mat be motified at  | Completed        | 15. Decedent's Education 16a. Decedent's Usu (Specify only highest grade completed) (Give kind of wo   | al Occupation<br>ork done during mo<br>ise retired) | ost of working  | 16                                  | b. Kind of Business/I             | ndustry                         |
| 7          | ithin<br>Ben *   | du               | Elementary/Secondary (0-12)   College (1-4or 5+)   |   |                 |                                     | - 171                             |                                 |
| 7          | ygier<br>ygier<br>nt, th   |                  | 12 Mail Ro   |   |                 | First, Middle, Ma                   | Publish                           | ing                             |
| 밀          | be fill<br>stal H<br>od otl  | Be               | 17. Father's Name (First, Middle, Last)  | 16. 1400  | •               | -iisi, wiiddie, wa                  | iden Sumame)                      |                                 |
| 2          | J Mer<br>J Mer<br>narke  | 10               | Thomas Baldwin  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address   | e (Street and Num                                   | F10             | Shame                               | T<br>City or Town, State, Z       | in Cade)                        |
| Maryland   | d2sl<br>than<br>7 Isr<br>treur   |                  |  |   |                 |                                     |                                   |                                 |
| Ġ,         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Increment of Health and Mental Hygiene. Increment of Health and Mental Hygiene. In the Madical Examinet matter and be notified at any injury or other treumatic event. It a Madical Examinet matter matter and because any injury or other treumatic event. It a Madical Examinet matter matter and because any injury or other treumatic event.   |                  | Kirby V. Miller (Son) 4211 Hil 20a. Method of Disposition (Na  | ICTEST<br>me of                                     | Ave.,           | Hamps                               | tead, MD<br>c. Location - City or | 0 2 1 0 7 4<br>Fown, State      |
| 0          | ages<br>int of<br>t: If it   |                  | Burial 2 Cremation 3 Removal from State  '4 Donation 5 Other (Specify)  Hamps + ond  |   | 10.15           |                                     |                                   |                                 |
| Baltimore, | artme<br>criten<br>Injur   | li               | - Hampstead  | nd Address of Faci                                  | 12-15           | -05 H                               | ampstead                          | MD 21074                        |
| Ba         | Dep<br>lmp<br>any  | B 1              | Koland & Start 1 Moosso Elin   | e Funer   | al Ho           | me                                  |                                   | 0.7.0.                          |
|            |  |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the model of the death.  | S. Maln<br>de of dying, such a                      | as cardiac or r | Hamps to spiratory arres            | ead, MD                           | o im te<br>Interval Between     |
|            | mysician   |                  | Immediate Cause (Final   |   |                 |                                     |                                   | Onset and Death                 |
|            | /Medical   |                  | disease or condition resulting in death)  Due to (or as a consequence of):   | indian.   |                 |                                     |                                   | ryen                            |
|            | Examiner   |                  | Sequentially list conditions b. Parking on   | sense   |                 |                                     |                                   | 15 ms                           |
| 1          |  | ē                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):   |   |                 | 200                                 |                                   |                                 |
|            | cuted<br>nd<br>ransii  | Examiner         | that initiated events c. Udwared Cy  | _   |                 |                                     |                                   | 78 gr                           |
| oʻ         | te be executed<br>ysician and<br>le burial-transit   |                  | resulting in death) Last Due to (or as a consequence of):  |   |                 |                                     |                                   | 0                               |
| <b>CD</b>  | 2 2 2  | lical            | d  |   |                 |                                     |                                   |                                 |
| 9          | death certifica<br>e attending ph<br>d for use as th   | Med              | IF FEMALE: 23c. If yes, outcome of pregnancy   |   |                 |                                     | 004 Date of dell                  |                                 |
| Вох        | ath c  | lan/             | in the past 12 months?   |   |                 |                                     | 23d. Date of deli<br>Month        | Day Year                        |
| o.         |  | Physiclan/M      | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (s  | Jocay)  |                 |                                     |                                   |                                 |
| ۵.         | es that the de<br>igned by the<br>be detached  |                  | Part II. Other significant conditions contributing to death but not resulting in the underlying  | cause given in Par                                  | rt I.           | 23e. Did toba                       | cco use contribute to             | the cause of death?             |
| ds,        | uires<br>sign<br>Id be   | d by             |  |   |                 | 1 🗆 Yes                             | 2 <b>1</b> No 3 □ Pro             | obably 4 \(\sum Unknown         |
| Record     | law requires<br>as been sign<br>2 should be  | Completed        |  |   |                 | 24a. Was an                         |                                   | topsy findings available        |
| Re         | o _ c  | m C              |  |   |                 | autopsy                             | d? death?                         | completion of cause of<br>2 No  |
| Vital      |  | O                | 25. Was case referred to medical   | 26. Pla   | ace of Death (  | 1 □ Yes 2 □<br>Check only one)      |                                   | 2010                            |
| >          | Physicien:<br>this certific<br>ral director,   | 0 8              | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D   | OA Other: 4 A                                       | Nursing Home    | s 5 ☐ Residen                       | ce 6 □Other (Spec                 | cify)                           |
| J Of       |  | i.               | 27. Manner of Death 28a. Date of Injury (Month, Day Year)  28b. Time of Injury   | 28c. Injury at<br>Work?                             | 28              | d. Describe how                     | injury occurred                   |                                 |
| 0          | Attending or death. ector: After by the fune   | atic             | 2 Accident investigation M   | 1 □ Yes 2[  | -               |                                     |                                   |                                 |
| Division   | or Att   | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)   | ry, office  | 28              | If. Location (Stre<br>City or Town, | et and Number or Ru<br>State)     | ıral Route Number,              |
|            | itel or rel D  |                  | <b>V</b>   |   |                 |                                     |                                   |                                 |
|            | To the Hospitel or within 24 hours after To the Funerel Director Completely filled in the Funerel or the Funerel Director Completely filled in the Funerel or the Funerel Order o | edical           | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurrer (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigatio and manner stated. |   |                 |                                     |                                   |                                 |
|            | thin 2<br>the outple   | Mec              |  | c. License numbe                                    |                 |                                     | 1. Date signed (Monti             |                                 |
|            | Mitt<br>Con  |                  | May May 18x -  | 1716  | 145             |                                     | 12/15/                            | ) cost                          |
|            | 4  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | シムタ   | 72              |                                     | 2/12/                             | 2003                            |
|            | 6,0  |                  | Tobal WM Additon 688 Poole Roll  | ed Wis  | estmin          | sten                                | 12/12/2<br>11 2 2/1               | 157                             |
|            | Sta  | ate              | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | - '   |                 | 1                                   |                                   |                                 |
|            | Regist   | rar              | DEC 1 4 2005 Johnson St. Joan  | de  |                 |                                     |                                   |                                 |

| Anthony Hunto<br>05-08328  | er                      | Moore, Jr. Please   | Type or Print in I<br>State of Marylar   |  |                                      |                         |   | -                  |   | _                                     |                                   |                      |  |  |
|--|-------------------------|---|--|--|--------------------------------------|-------------------------|---|--------------------|---|---------------------------------------|-----------------------------------|----------------------|--|--|
| crn  |                         | 1 - For<br>State<br>Registrar   | State of Marylar   |  |                                      | te of D                 |   |                    | Reg. No.  | 7000                                  | 623                               | 47                   |  |  |
| Physic   | ian                     | 1. Decedent's Name (First, Middle, Las  |  |  |                                      |                         |   | 2. Date of Dea     |   | ), 20°05                              | 3. Time of                        |                      |  |  |
| /Medi  | cal                     | ANTHONY HUNTER  4a. Facility Name (If not institution, give   |  |  | 4b. City                             | , Town, or I            | Location of Deat                                    | Decembe<br>h       | _   | County of Death                       | 2:29                              | Ам                   |  |  |
| Exami  | iei                     | Route 202 at Inter  | state 495  |  | 1                                    | ndove                   |   |                    |   | cince Geo                             |                                   |                      |  |  |
| Funeral<br>Director  |                         | 5. Social Security Number 6. Social Security Number 213-04-9131  Usual Residence of Decedent  | ex 7. Age (In yrs.<br>▼ M 2□ F 23  | last birthday)<br>Yrs.                     | Months                               | Days                    | Hours Min.  |                    | v. Year)  | 9. Birthp<br>Cour<br>982 WASH         | lace (State of<br>htry)<br>INGTON | , DC                 |  |  |
| tryland<br>show  |                         | 10a. State 10b. County  |  | ty, Town or Lo                             |                                      |                         |   |                    |   | 10d. Inside City Limit 1X Yes 2 □ N   |                                   |                      |  |  |
| the Ma<br>28a-f  | recto                   | MD PRINCE G   | EORGE'S CA   | APITAL                                     | _                                    | p Code                  |   |                    | 10g. Citi   | 0g. Citizen of What Country?          |                                   |                      |  |  |
| nd 21215-0036  e filed within 72 hours after death with the Maryland at Hygiene. I other then "natural", or items 23e or 28e-f show vent, the Madical Exeminat must be notified at.  | <b>Funeral Director</b> | 1115 61st AVENUE  |  |  | 2                                    | 0743                    |   |                    | U   | .S.A.                                 |                                   |                      |  |  |
| ter dea  | une                     | 11. Marital Status 1 ⊠ Never Married 2 ☐ Married  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 🛱 No  | spanic Origin? (S<br>i, Mexican, Puer      | pecify Yes or No-<br>to Rican, etc.) |                         | <ol> <li>Race - Americ<br/>Black, White,</li> </ol> |                    |   |                                       |                                   |                      |  |  |
| 036<br>Durs aff  | Š                       | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:   |  | 1 🗆 Yes                              | 2 <b>K</b> ) No         | Specify:  |                    |   | Specify: BLACK                        |                                   |                      |  |  |
| 15-0   | letec                   | 15. Decedent's Ed<br>(Specify only highest gra  |  | 16a. Dece<br>(Give                         | dent's Use<br>kind of w              | ual Occupations done du | tion<br>uring most of wo                            | rking              | 16b. Ki   | nd of Business/Ind                    | dustry                            |                      |  |  |
| 212<br>d with<br>giene.  | Completed               | Elementary/Secondary (0-12)<br>12th   | College (1-4or 5+)   | NONE                                       |                                      | ,                       |   |                    | N   | ONE                                   |                                   |                      |  |  |
| Maryland 21215-0036 nd 2 should be filed within 72 hours all the and Mental Hygiene. 27 ie marked other then "natural", or rireumatic event, the Madical Exami   | Be                      | 17. Father's Name (First, Middle, Last)   |  |  |                                      |                         |   | me (First, Middle, |   |                                       |                                   |                      |  |  |
| Aaryland<br>2 should be f<br>1 and Mental I<br>1 ie marked or  | 7                       | ANTHONY HUNTER M 19a. Informant's Name/Relationship (   |  | 19b. Maili                                 | ing Addres                           | s (Street a             |   | TINE ROB           |   | City or Town, State, Zip Code)        |                                   |                      |  |  |
| Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or items 23a or 28a-f show my injury or other treumatic event, the Madical Examinat her nutified at once. |                         | ERNESTINE WILLIAM   |  |  |                                      |                         | UE CAPI   | TAL HEIG           |   | S, MARYLAND 20743                     |                                   |                      |  |  |
| ages 1<br>ant of H<br>t: if ite  |                         | 20a. Method of Disposition  1 <sup>2</sup> Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify   | Removal from State   | Place of Dispo<br>cemetery, cre<br>SURREC' | matory or                            | other place             |   | 17/2005            | 20c. Location - City or Town, State  5 CLINTON, NMARYLAND |                                       |                                   |                      |  |  |
| Baltimore, semit. Pages 1 er apparant of Hee mportant if Item mportant if Item my injury or othe ance.   |                         | 21. Signature of Funeral Service Licen  | ,  |  |                                      |                         | 1   |                    |   | 5 FUNERAI                             |                                   |                      |  |  |
| 0 40 5 8   |                         | K. D. H   | Lall   |  |                                      |                         |   |                    |   | ARYLAND 2                             | 20785<br>Approximate              |                      |  |  |
| Physician<br>/Medical<br>Examiner  |                         | 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate.  Due to (or as a consequence of): |  |  |                                      |                         |   |                    |   |                                       |                                   |                      |  |  |
| po tis   | amlner                  | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury   |  | 1  |                                      |                         |   |                    |   |                                       |                                   |                      |  |  |
| 68760, rificate be executed graphysicien and as the burial-transit   |                         | that initiated events resulting in death) Last  |  |  |                                      |                         |   |                    |   |                                       |                                   |                      |  |  |
| ( 68° striffcat ing phy  | Medi                    | IF FEMALE:  |  |  |                                      |                         | 1-  |                    |   |                                       |                                   | -                    |  |  |
| Division of Vital Records, P.O. Box 68760, or Attending Physician: The lew requires that the death certificate be extra death. Director: After this certificate has been signed by the attending physicien in by the tuneral director, page 2 should be delached for use as tha burial in by the tuneral director.         | Physician/Medical E     | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of of<br>9 ☐ Unknown | el death 3[                                | ⊒Ectopic  <br>⊒ Other (s             |                         |   |                    |   | 23d. Date of delive<br>Month          |                                   | 'ear                 |  |  |
| S, P.  | by Pt                   | Part II. Other significant conditions of  | ontributing to death but not re-   | sulting in the u                           | underlying                           | cause give              | n in Part I.  | 23e. Did to        | obacco u  | use contribute to the                 |                                   |                      |  |  |
| ord:<br>require  |                         |   |  |  |                                      |                         |   | 1 🗆 \              |   |                                       | oably 4 DU                        | _                    |  |  |
| Division of Vital Records, i or Attending Physician: The lew requires to after cleath.  Director: After this certificate has been signed in by the funeral director, page 2 should be  | Completed               |   |  |  |                                      |                         |   |                    | rmed?   | geat)2                                | mpletion of ca                    | available<br>ause of |  |  |
| Vital Fictan: The certificete  | Be C                    | 25. Was case referred to medical examiner?  |  |  |                                      |                         |   | ath Check only o   | 2∐ No<br>ne)  | Nes                                   | 2 No                              |                      |  |  |
| on of Vita<br>ding Physician:<br>h.<br>After this certific   | ို                      | 1 ☑ Yes 2 ☐ No 27. Manner of Death  | Hospital: 1 ☐ Inpatient 2 ☐  | ER/Outpatie                                |                                      |                         | 4 🗆 Hursing t                                       | dome 5 Resid       |   | 6 Other (Specif                       | y) at so                          | ene                  |  |  |
| ion onding the rich After rich After e funer   | Certification:          | 1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)   | 28c. Injury<br>Work<br>1 🗌 Y               |                                      | Sub                     | عد  | \$ 8Lof            | 1   |                                       |                                   |                      |  |  |
| ivisio<br>or Attendi<br>ftar death<br>virector: A  | riffe                   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                      |                         |   |                    |   |                                       | I Route Num                       | ber,                 |  |  |
| Hospitel or Hours a Funerel E  |                         |   | ysician: To the best of my kn  |  |                                      |                         |   |                    | cause(s)  |                                       |                                   | 0780                 |  |  |
| Divis To the Hospitel or Attu within 24 hours after de To the Funeral Direct completely filled in by 11  | Aedical                 | one) X  | niner: On the basis of examin<br>and manner stated.  | ation and/or in                            |                                      |                         |   |                    |   |                                       |                                   | )                    |  |  |
| or viit  | Σ                       | 29b. Signature and title of certifier   | 0  |  | 2                                    | 9c. License<br>O.       | C.M.E.  |                    |   | te signed <i>(Month,</i><br>ember 10, |                                   |                      |  |  |
| CR (2)   |                         | 30. Name and address of person who  | completed cause of death (Ite  | m 23a) (Type                               | , Print)                             |                         |   |                    |   | ,                                     |                                   |                      |  |  |
| U C  |                         | 31. Date filed (Month, Day, Year)   | DE Registrar's Sign  |  | Penn                                 | Stree                   | et, Balt  | imore, M           | ary1  | and 2120                              | 1                                 |                      |  |  |
| St<br>Regist   | ate<br>trar             | DEC 1 6 200   |  | A.   | W.                                   |                         |   |                    |   |                                       |                                   |                      |  |  |

|                     |  |                | For<br>State<br>Registrar  | State of Maryland   |                               | artment of H<br>rtificate of L                                    |                                   |   | Reg. No.                                 | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,                       |  |  |
|---------------------|--|----------------|--|---|-------------------------------|---|-----------------------------------|---|--|---|--|--|
|                     | Physicia   | an             | Decedent's Name (First, Middle, Last,                            |   |                               |   |                                   | 2. Date of De<br>Month                      | Day Y                                    | 3. Time of Death  |  |  |
|                     | /Medic   |                | Hattie Louis   |   |                               | # 63 T  | 1 1 1 1                           | Decembe                                     |  | 05 9:00 A M   |  |  |
|                     | Examin   | er             | 4a. Fecility Name (If not institution, give 3317 Michele L       |   |                               | 4b. City, Town, or M-1 +  | chelly                            |   | 4c. County of                            | ce George's   |  |  |
|                     | <b>F</b>   |                | 5. Social Security Number 6. Sec                                 |   | ast birthday)                 | If Under 1 Year   | If Under 24                       | Hrs. 8 Date of Birt                         | 8 Date of Birth 9 Birtholace             |   |  |  |
|                     | Funeral<br>Director  |                | 577 <b>-</b> 32 <b>-</b> 1214                                    | M 2K) F 81  |                               | Months Days   | Hours N                           | Min. (Month, Da<br>Aug. 3                   |  | N. Birthplace (State or Foreign Country)  Wash., DC           |  |  |
|                     | p.   |                | Usual Residence of Decedent                                      |   |                               |   |                                   |   |  |   |  |  |
|                     | show   | _              | 10a. State 10b. County   |   | , Town or Lo                  | cation  |                                   |   |  | 10d. Inside City Limits 1 XYes 2 ☐ No                         |  |  |
|                     | he M.  | Director       | Maryland Prince G  | eorge's   | M:                            | itchellvi   | 11e                               |   | 10g. Citizen of Wh                       |   |  |  |
|                     | a or   |                | 3317 Michel  | o I ano   |                               | 10f. Zip Code   | 20721                             |   |  |   |  |  |
|                     | death  | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in U.S                                      | S. 13. V                      | Was Decedent of Hi  |                                   | ? (Specify Yes or No<br>uerto Rican, etc.)  |  | ed States American Indian,                                    |  |  |
| ယ                   | or iter  | 듄              | 1 ☐ Never Married 2 🕅 Married                                    | Armed Forces?<br>1 ☐ Yes 2 ☐XNo                                   |                               |   |                                   | uerto Rican, etc.)                          |  | White, etc.   |  |  |
| <u>8</u>            | 72 hours after death with the Maryland<br>natural', or items 23a or 28a-f show<br>sical Examiner must be notified at   | l by           | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:                                    |                               | 1 ☐ Yes 2 🔀 No  | Specify:                          |   | Specify:                                 | Black   |  |  |
| Maryland 21215-0036 | be filed within 72 hours after death with the Marylan ital Hygiene. or other than "naturel", or items 23a or 28a-f show ovent, it e Marical Examiner must be notified at | Completed      | 15. Decedent's Edu<br>(Specify only highest grad                 | lcation<br>le completed)  | 16a. Deced<br>(Give           | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired | ation<br>during most of           | working                                     | 16b. Kind of Busi                        | ness/Industry   |  |  |
| 121                 | within<br>ene.<br>than "   | d L            | Elementary/Secondary (0-12)<br>12th                              | College (1-4or 5+)  | ine. i                        |   |                                   |   | Donat                                    |   |  |  |
| d 2                 | e filed v<br>il Hygie<br>other i<br>vent, II   |                | 17. Father's Name (First, Middle, Last)                          | 1   |                               | House   |                                   | Name (First, Middle,                        |  | vate  |  |  |
| an                  | ld be<br>ental<br>ked o  | To Be          | Eker J.  | Sewell  |                               |   |                                   | Anna  | a William                                | S   |  |  |
| ary                 | 2 should be f<br>and Mental I<br>la marked of<br>raumatic eve  | -              | 19a. Informant's Name/Relationship (T)                           | vpe, Print)   | 19b. Mailir                   | ng Address (Street a  | and Number o                      | or Rural Route Number                       | er, City or Town, St                     | ate, Zip Code)  |  |  |
|                     | s 1 and 2 should<br>f Health and Mer<br>item 27 la marke<br>other traumatic  |                | Elmer H. Meadow  | s/Husband   | 33                            | 17 Michel   | e Lane                            | , Mitchell                                  | lville, M                                | D 20721   |  |  |
| Baltimore,          | of Health<br>of Health<br>fitem 27<br>r other tr   |                | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F        |   | ace of Dispo<br>metery, crer  | sition (Name of<br>matory or other plac                           | e)                                | Date  | 20c. Location - Ci                       | ty or Town, State   |  |  |
| Ĕ                   | Pag<br>ment<br>ant: I<br>ury o   |                | ' 4 ☐ Donation 5 ☐ Other (Specify)                               | Mt  |                               | vet Cemet   |                                   |   | Wash.,                                   |   |  |  |
| Salt                | permit. Pages 1<br>Department of H<br>Important: If ite<br>any injury or ot<br>once.   |                | 21. Signat te of Furieral Service Licens                         | P H   | 22                            | 2. Name and Addres  |                                   |   | Funeral                                  |   |  |  |
|                     | 703 9 Q  | Н              | 23a. Party Enter the disease, or compl                           | Landa III   | Do not ont                    |   |                                   | Rd., N.E.                                   |  | DC 20019<br>Approximate                                       |  |  |
| ı                   |  |                | shock, or heart failure. List only o                             | ne cause on each line.  |                               |   |                                   | diac or respiratory a                       | 11031,                                   | Interval Between<br>Onset and Death                           |  |  |
|                     | Fnysician<br>/Medical  |                | disease or condition resulting in death)                         | aCongestive   |                               | t Failure   |                                   |   |  |   |  |  |
| 8                   | Examiner   |                |  | Cardiomwor  |                               |   |                                   |   |  |   |  |  |
|                     | 335  | Je.            | if any leading to immediate                                      | Due to (or as a consequ   |                               |   |                                   |   |  |   |  |  |
|                     | cuted<br>nd<br>ransit  | Examine        | Cause (Disease or injury that initiated events                   | c. Renal Fail   |                               |   |                                   |   |  |   |  |  |
| <u>3</u> 0,         | sician and burial-transit  | Ë              | resulting in death) Last   | Due to (or as a consequ   | ence of):                     |   |                                   |   |  |   |  |  |
| 8760                | ate<br>hy<br>he  | dical          |  | d   |                               |   |                                   |   |  |   |  |  |
| 9 X                 | certific<br>anding pl<br>use as t  | Physician/Me   | IF FEMALE:   | 23c. If yes, outcome of pregnar                                   | ncy                           |   |                                   |   | 23d. Date 0                              | of delivery   |  |  |
| Вох                 | eath<br>atter<br>I for u   | clar           | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | 1 ☐ Live birth 2 ☐ Fetal<br>4 ☐ Pregnant at time of de            |                               | Ectopic pregnancy Other (specify)                                 | ·                                 |   | Month                                    |   |  |  |
| O.                  | that the de<br>led by the<br>detached  | hysi           | 9 Unknown  | 9□ Unknown  |                               |   |                                   |   |  |   |  |  |
| S, D                | The law requires that the ite has been signed by th bage 2 should be detache   | by P           | Part II. Other significent conditions co                         | ntributing to death but not resu                                  | lting in the u                | nderlying cause give  | en in Part I.                     |   | **                                       | ute to the cause of death?                                    |  |  |
| ğ                   | v require<br>been sig<br>should b  |                |  |   |                               |   |                                   | _ 1□`                                       | Yes 2≹No 3                               | ☐ Probably 4 ☐ Unknown  |  |  |
| ecc                 | e law r<br>has be<br>ge 2 sh   | Completed      | Diab   | etes Mellitus   |                               |   |                                   | 24a. Was                                    | osy prio                                 | re autopsy findings available<br>or to completion of cause of |  |  |
| = =                 |  | Co             |  |   |                               |   |                                   | perfo<br>1 ☐ Yes                            | rmed? dea<br>2 X No 1 L                  | ath?<br>I Yes 2 🗌 No  |  |  |
| Vita                | ician:<br>certific<br>rector,  | Be             | 25. Was case referred to medical examiner?                       | Hospital:   |                               | Othe  |                                   | Death (Check only o                         |  |   |  |  |
| of Vital Records,   | Phys<br>this<br>al di  | . To           | 1 ☐ Yes 2 🛣 No   | 1   Inpatient 2   E   | ER/Outpatier<br>28b. Time o   |   | er: 4 ☐ Nursin                    |   | dence 6 Other                            |   |  |  |
| On                  | ding<br>h.<br>After<br>fune  | tion           | 1 Natural 5 Pending 2 Accident Investigation                     | 28a. Date of Injury<br>(Month, Day Year)                          | Injury                        | Worl  | k?`<br>Yes 2 □ No                 |   |  |   |  |  |
| Division            | or Attending<br>after death.<br>Director: After<br>in by the fune  | ifica          | 3 Suicide 6 Could not be determined                              | 28e. Place of Injury - At hor                                     | me, farm, str                 | reet, factory, office   |                                   |   |  | or Rural Route Number,  |  |  |
| Ö                   | i Dir  | Certification: | 4   Holfricide   | building, etc. (Specify,  | ,                             |   |                                   | City or Tou                                 | WI, SIBIO)                               |   |  |  |
|                     | To the Hospital<br>within 24 hours of<br>To the Funeral<br>completely filled   | edicai (       | (Check only 2 Medical Exami                                      | sician: To the best of my know<br>inar: On the basis of examinati | vledge, deat<br>ion and/or in | h occurred at the tin<br>vestigation, in my o                     | ne, date and p<br>pinion, death o | place, and due to the occurred at the time, | cause(s) and mann<br>date and place, and | er as stated.<br>I due to the cause(s)                        |  |  |
|                     | To the Hos<br>within 24 h<br>To the Fun<br>completely  | Med            | 29b. Signature and title of certifier                            | and manner stated.  |                               | 29c. License  |                                   |   | 29d. Date signed (                       |   |  |  |
|                     | 5 1 × 1 8  |                | August allo  | test Nemes  | NAID                          |   | D2807                             |   |  | er 14, 2005   |  |  |
| n                   | (2)  |                | 30. Name and address of person who co                            | ompleted cause of death (Item                                     | 23a) (Type.                   | Print)  | 52007                             |   | Decemb                                   | C. 1-19 2003  |  |  |
|                     | (4)  |                |  | iggs-Shipman,   | M.E.,                         | 11700 в   | eltsvi                            | 11e Rd., E                                  | Beltsvill                                | e, MD 20705   |  |  |
|                     | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)  DEC 1 6 2005                  | . Registrar's Signat  | ure Sau                       | di di   |                                   |   |  |   |  |  |

|  |   |                | For   | State of                                |                           | nd / Depa                   | artmen                            | t of He                          | alth an                     |                          | •                            |              | igibie.                 | 42349  |
|--|---|----------------|---|---|---------------------------|-----------------------------|-----------------------------------|----------------------------------|-----------------------------|--------------------------|------------------------------|--------------|-------------------------|--|
|  |   |                | 1 - State<br>Registrar  |   |                           | Ce                          | rtificat                          | e of D                           | eath                        |                          |                              | eg. No.      | 100                     |  |
| Ph   | ysicia  | an             | Decedent's Name (First, Middle, L.  | ast)                                    |                           |                             |                                   |                                  |                             |                          | Date of Dea<br>Month         | Day          | Year                    | 3. Time of Death                                   |
| //\  | Medic   | al             | Darren Moss  4a. Fecility Name (If not institution, gr  | ive street and num                      | her)                      |                             | 4h City                           | Town or Lo                       | ocation of D                |                          | cembe                        |              | 2005<br>unty of Dea     |  |
| Ex   | amin  | er             | Woodside Center   |   | 5017                      |                             |                                   | er Sp                            |                             | ,0411                    |                              |              | gomer                   |  |
| Fun  | eral  |                | Social Security Number     6.   | Sex 7                                   | . Age (In yrs.            | last birthday)              |                                   | 1 Year   I                       | f Under 24 l                | Hrs. 8. I                | Date of Birth<br>Month, Day  | Year)        | 9. Bi                   | rthplace (State or Foreign ountry)                 |
| Dire   | _   |                | 578-90-2789   | 1√2M 2□ F                               | 44                        | Yrs.                        | WICHTIS                           | Days                             | riours is                   | Se                       | pt. 2                        | 9,196        | 1 Wa                    | shington, DC                                       |
| and  | **  |                | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. Ci                   | ty, Town or Lo              | ocation                           |                                  |                             |                          |                              |              | <del></del>             | 10d. Inside City Limits                            |
| Maryi<br>-feho   | ied a   | tor            | Maryland Montgom  | erv                                     | Si                        | lver S                      | oring                             |                                  |                             |                          |                              |              |                         | 1 ☐ Yes 2 ☐ No                                     |
| h the  | ruoti   | Director       | 10e. Street and Number  |   |                           |                             | 10f. Zip                          | Code                             |                             | -                        | 1                            | 0g. Citizen  | of What C               | ountry?  |
| IIIQ X IX I 2-0000<br>be filed within 72 hours after death with the Maryland<br>tal Hygiene.<br>d other then "neturel", or tlems 23a or 28e-f ehow | ustbe   |                | 957 East West Hig   | hway Apt                                | . 17                      |                             |                                   | 20912                            | 2                           |                          |                              | U.           | S.A.                    |  |
| er dea   | in the  | Funeral        | 11. Marital Status  | 12. Was Deced<br>Armed Ford             | es?                       | l.S. 13.                    | Was Deced<br>If Yes, spec         | lent of Hisp<br>offy Cuban,      | anic Origin?<br>Mexican, Pi | ? (Specify<br>uerto Rica | Yes or No-<br>in, etc.)      | 14.          | Race - Am<br>Black, Whi | erican Indian,<br>te, etc.                         |
| s afte   | rami  | by F           | Never Married 2 Married 3 Widowed 4 Divorced  | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Da | No<br>Nes:                |                             | 1 ☐ Yes                           | 2[XNo .                          | Specify:                    |                          |                              | Spe          | ecify: p.1              | a a l•   |
| 2 hou  | ESIE  | led t          | 15. Decedent's  | Education                               |                           | 16a. Dece                   | dent's Usua                       | al Occupation                    | on .                        |                          |                              | 16b. Kind o  |                         | ack<br>Vindustry                                   |
| hin 73   | Medi  | ple            | (Specify only highest g<br>Elementary/Secondary (0-12)  | rade completed) College (1-             | 4or 5+)                   | (Give                       | kind of wor<br>DO NOT us          | rk done dur.<br>se retired)      | ing most of                 | working                  |                              |              |                         |  |
| ylalla 212<br>buld be filed with<br>Mental Hygiene.<br>arked other ther  | g I   | Completed      | 12  |   |                           | Ve                          | ender                             |                                  |                             |                          |                              |              | ling                    |  |
| be fill the day  | even  | Be             | 17. Father's Name (First, Middle, Las   | st)                                     |                           |                             |                                   | 18                               |                             |                          | rst, Middle,                 | Maiden Sur   | name)                   |  |
| Z should be filed within and Mental Hygiene.  Is marked other then   | netic   | <sup>2</sup>   | Alonzo Moss  19a. Informant's Name/Relationship   | (Type Print)                            |                           | 10h Maili                   | na Address                        | (Street and                      | Cloat                       |                          | Wil:                         | liams        | um State                | Zin Code)  |
| and 2 si<br>and 2 si<br>ealth an   | other treumetic event. The Madical Examinar must be notified at |                | Wanda Shorter-Mos   |   |                           |                             |                                   |                                  |                             |                          | hingt                        |              |                         |  |
| permit. Pages 1 and 2 Department of Health a Importent: If item 27 is  | other   |                | 20a. Method of Disposition  |   | 20b. F                    | Place of Dispo              |                                   |                                  | ve. Nu                      | Date                     |                              |              |                         | Town, State  |
| Pages<br>nent of<br>nut: If it   | ry or   |                | 1 ☑ Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec  | □Removal from S<br>cify)                | tate                      | tional                      |                                   |                                  | P 12/                       | /14/2                    | 005                          | Landov       | ver. 1                  | MD   |
| permit. Pages Department of Importent: If it   | any inju  |                | 21. Signature of Funeral Service Lio  | ensee /                                 | 1                         |                             |                                   |                                  |                             |                          | Linco                        |              |                         |  |
| 0 &8E  | E 8   |                | Van T.  | Miles                                   |                           |                             |                                   |                                  |                             |                          | Brent                        |              |                         |  |
|  |   |                | 23a. P. 11. Inter the disease, or co  | y one cause on ea                       | used the deat<br>ch line. | th. Do not ent              | ter the mod                       | e of dying,                      | such as car                 | rdiac or res             | spiratory arr                | est,         |                         | Approximate<br>Interval Between<br>Onset and Death |
| Physic   |   |                | Immediate Cause (Final disease or condition resulting in death)   |   | al Can                    |                             |                                   |                                  |                             |                          |                              |              |                         | Onset and Death                                    |
| /Med<br>Exam   |   |                | 1950kiilig iii dodiily  |   | r as a consec             |                             |                                   |                                  |                             |                          |                              |              |                         |  |
|  |   | er             | Sequentially list conditions, if any, leading to immediate the first Interving Cause (Disease or injury |   | astation as a consec      | c Cance quence of):         | er                                |                                  |                             |                          |                              |              |                         |  |
| uted   | ansit   | Examiner       | Cause (Disease or injury that initiated events  | 0                                       |                           |                             |                                   |                                  |                             |                          |                              |              |                         |  |
| ( ou,<br>te be executed<br>ysician and   | he burial-transit   | Exa            | resulting in death) Last  | Due to (c                               | r as a consec             | quence of):                 |                                   |                                  |                             |                          |                              |              |                         |  |
| ate be   | the bu  | lical          |   | d                                       |                           |                             |                                   |                                  |                             |                          |                              |              |                         |  |
| The Colds, F.C. box 60  The law requires that the death certifica ate has been signed by the attending ph  | should be detached for use as the                               | Physiclan/Med  | IF FEMALE:  | 23c. If yes, outc                       | ome of pream              | ancv                        |                                   |                                  |                             |                          |                              | 224          | Data of da              | 1  |
| eath c   | for u   | clan           | 23b. Was decedent pregnant in the past 12 months?   | 1☐Live bir                              | th 2 Feta                 | aldeath 3                   | ∃Ectopic pr<br>∃ Other <i>(sp</i> |                                  |                             |                          |                              | 230.         | Date of de<br>Month     | Day Year   |
| the d  | ached   | ysi            | 1 □ Yes 2 □ No<br>9 □ Unknown   | 9 Unknow                                |                           |                             |                                   | //                               |                             |                          |                              |              |                         |  |
| s that   | e det   | by P           | Part II. Other significant conditions   | contributing to dea                     | ath but not res           | sulting in the u            | nderlying c                       | ause given                       | in Part I.                  |                          | 23e. Did tol                 | bacco use o  | contribute t            | o the cause of death?                              |
| law requires that as been signed   | should b  |                |   |   |                           |                             |                                   |                                  |                             |                          | 1 □ Y                        | es 2□N       | o 3□P                   | robably 4 💆 Unknown                                |
| law re   | 2 sho   | plet           |   |   |                           |                             |                                   |                                  |                             |                          | 24a. Was a autops            |              | b. Were a               | utopsy findings available completion of cause of   |
|  | page  | Completed      |   |   |                           |                             |                                   |                                  |                             |                          | perform                      |              | death?                  | s 2□No   |
| VII.dl<br>iclen:<br>bertifica  | l director, page 2 s  | Be             | 25. Was case referred to medical examiner?  | Hospital:                               |                           |                             |                                   | Othor                            | 6. Place of                 | Death (Ch                | neck only on                 | e)           |                         |  |
| Phys   | ral dır   | To:            | 1 ☐ Yes 2 ☑ No 27. Manner of Death  | 1 Din                                   |                           | ER/Outpatier<br>28b. Time o |                                   | A                                |                             |                          | 5 Reside                     |              |                         | ecify)   |
| ding I<br>th.  | fune  | ıtlon          | 1 X Natural 5 ☐ Pending 2 ☐ Accident investigati  | (Month                                  | , Day Year)               | Injury                      | М                                 | 8c. Injury at<br>Work?<br>1  Yes | s 2 No                      |                          |                              | , , , , ,    |                         |  |
| Attending or death.  | by the  | ifica          | 3 Suicide 6 Could not 4 Homicide determine  | d Zee. Place                            | of Injury - At h          | ome, farm, sti              | reet, factory                     | , office                         |                             |                          | Location (SI<br>City or Town |              | umber or R              | ural Route Number,                                 |
| tel or safte   | ed in   | Certification; | 4 - Homelde   | ballalli                                | g, etc. (Specia           |                             |                                   |                                  |                             |                          |                              | i, otato)    |                         |  |
| DIVISION OF VICE  To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific               | completely filled in by the funeral                             | edical         | (Check only 2 Medical Ex  | Physician: To the teminer: On the ba    | sis of examina            |                             |                                   |                                  |                             |                          |                              |              |                         |  |
| To the<br>within 2<br>To the   | mplet   | Med            | one) 29b. Signature and title of certifier  | and mann                                | er stated.                |                             | 290                               | . License n                      | umber                       |                          | 2                            | 9d. Date sig | gned (Mon               | th, Day, Year)                                     |
| F 3 F  | ö   |                | 1 Rehard  | 4/                                      | ANT                       | )                           |                                   | 32332                            |                             |                          |                              |              | 2/200                   |  |
| 2/1  | )   |                | 30-Hame and address of person wh  | o completed cause                       | of death (Ite             | m 23a) (Type,               |                                   |                                  |                             |                          | and the                      |              | _,,                     |  |
| - 3  |   |                | Suresh K. Gupt  | a, MD 98                                |                           | orgia A                     |                                   | Suite                            | 2-20                        | Silv                     | er Spi                       | ing,         | MD 20                   | 0902   |
|  | Sta   |                | 31. Date filed (Month, Day, Year).  DEC 1 5 20  | ns Re                                   | gistrar's Sign            | ature 6                     | - A A                             |                                  |                             |                          |                              |              |                         |  |
| Re   | egistr  | ar             | DEO 1 2 20  | US JUDE                                 | W D                       | 147                         | -                                 |                                  |                             |                          |                              |              |                         |  |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** 11,2005 Margaret H. Mackey December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Elkton Laurelwood Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, July 15, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 □ **X**F Maryland 1908 215-32-6719 **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State or 28e-f show other traumatic evant, the Medical Evaniner must be notified at 1 Yes 2 No Director Elkton Cecil MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA or Items 23e 21921 100 Laurel Drive Funeral Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ent: If itam 27 is marked othar then "natural", or Items 23dury or other traumatic evant, it with without the must 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes. Give Was Oecadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ XNo Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Q. Hudson Carrie Lusby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 69 Ridge Road, Rising SUn, MD C. Vernon Mackey/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of importent: If any injury or once. 12-15-2005 Rising Sun, Maryland 14 ☐ Donation 5 ☐ Other (Specify) Brookview Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility R.T. Foard Funeral Home, Inc. 111 S. Queen Street, Rising Sun, MD uchang 010 complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one car is on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one car Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MOON Sequentially list conditions, if any, leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or sella consequanca of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 No 2 No 1 Yes 1 Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 Yes 2 No М 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the within 24 hours at the Funeral Directory of the Funeral Directory of the Funeral Directory of the funeral Directory of the funeral Directory of the funeral Directory of the funeral Directory of the funeral Directory Certifying P ysicia 4. To the best of my knowledge, Jeath occurred at the time, date and place, and due to the causa(s) and marmer as stated.

— Medigat/que iner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) 29a, Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 1013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Arlen Stone 817 Churchman's Road, New Castle, DE 32. Registrar's Signatur 2005 Registrar

|   |                          |          | riease i   | State of Manda  |              |                                      |                                      |              | -                           |                | _                           |  |
|---|--------------------------|----------|--|---|--------------|--------------------------------------|--------------------------------------|--------------|-----------------------------|----------------|-----------------------------|--|
|   |                          | 1        | For State  | State of Marylai  |              |                                      | e of Deal                            |              | nemai ny                    | 0              | 001                         | 1.2251   |
|   |                          |          | 1. Decedent's Name (First, Middle, Last)   |   |              | Jertincat                            | e oi Deal                            |              | 2. Date of D                | Rag. No        | 0.00                        | 3. Time of Death                                   |
| Phys  | siciar                   |          |  |   | M            | rack                                 | , Jr.                                |              | Month                       | Da             |                             |  |
|   | dica                     |          | James  Aa. Facility Name (If not institution, give s   | treet and number)   | 1011         |                                      | Twn. or Location                     |              | Decemb                      | -              | . County of Dea             |  |
| Exa   | mine                     | ш.       | The Johns Hopkins  | 24  |              |                                      | Itimore                              |              | itu                         |                |                             | •••  |
| Funei   | ral                      |          | 5. Social Security Number 6. Sex   | 7. Age (In yrs  | . last birth | day) If Under                        | 1 Year If Und                        | der 24 Hrs.  | 8 Date of Bi<br>(Month, D   | rth            | 9. Bi                       | rthplace (State or Foreign                         |
| Direct  |                          |          | 215–30–9432  | <sup>M 2□ F</sup> 73                                      | Υ            | months                               | Days Hour                            | rs Min.      | Decembe                     | er 1           | 1932 P                      | ennsylvania  |
| P 2   | 0                        | <u>}</u> | Usual Residence of Decedent  10a. State 10b. County  | 10c C   | ity Town     | or Location                          |                                      |              |                             |                |                             | 10d. Inside City Limits                            |
| anyla<br>ehov   |                          |          |  |   |              |                                      |                                      |              |                             |                |                             | 1 Tyes 2 No  |
| the N   |                          | 2        | Maryland Anne Aru  | naer C  | hurc         | 10f. Zip                             | Code                                 |              |                             | 10a Cit        | izen of What C              | Country?   |
| death with the Maryland<br>me 23a or 28a-f show   | Ž                        | 2        | 5718 North Shore   | Darkway   |              | 207                                  |                                      |              |                             | USA            |                             | outriy.  |
| death   |                          | 2        |  | 2. Was Decedent Ever in I                                 | J.S.         |                                      | dent of Hispanic<br>city Cuban, Mexi | Origin? (Sp  | ecify Yes or N              |                | 14. Race - Am               |  |
| after or lte  | i                        |          | 1 ☐ Never Married 2 ☑ Married  | Armed Forces?  1  | 53-          |                                      |                                      |              | Rican, etc.)                |                | Black, Wh                   | •  |
| 2-UUSO 72 hours after hatural', or its  |                          | 2        | 3 Widowed 4 Divorced   | Year or Dates:  | 55           | 1 🗆 Yes                              | 2⊠ No Spec                           | ony:         |                             |                | Specify: VV                 | iiice  |
| 72 h  |                          |          | 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)                                       | 1            | Give kind of wo                      | rk done during n                     | nost of work | ing                         |                | ind of Busines              | ,  |
| within ene.   |                          | 2        | Elementary/Secondary (0-12)  | College (1-4or 5+)  |              | life. DO NOT u<br>Nager              | se retired)                          |              |                             | 0.5            | . Posta                     | l Service  |
| N 200   | 3                        | 3        | 17. Father's Name (First, Middle, Last)  |   | Pict         | ager                                 | 18. Mc                               | other's Nam  | e (First, Middle            | a. Maiden      | Sumame)                     |  |
|   |                          | ā        | James Mirack, Sr   |   |              |                                      | 7                                    | Anna         |                             |                | Nolew                       | ak   |
| arytar<br>2 should be<br>and Mental<br>1s marked<br>eumatic ev  | 1                        | -  -     | 19a. Informant's Name/Relationship (Type   |   | 19b.         | Mailing Address                      | (Street and Nut                      | mber or Rur  | rai Route Numi              | oer, City      | or Town, State,             | Zip Code)  |
| 127 FB Z  |                          |          | Georgeanne R. Mi   | rack - Wife   | 57           | 18 Nort                              | h Shore                              | Pkwy.        | , Churc                     | chtor          | n, MD                       | 20733  |
| or Head   |                          |          | 20a. Method of Disposition   | 20b.  | Place of I   | Disposition (National Communication) | me of other place)                   |              | Date                        | 20c. L         | ocation - City o            | r Town, State                                      |
| Baitimor permit. Pages Department of Important: If Ite  |                          |          | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  | niiovai iioiii State                                      | _            | _                                    | rans Cen                             | 1 12-1<br>n. | 5–2005                      | Crov           | vnsville                    | e, Maryland  |
| milit.  | once.                    |          | 21. Signators of Funeral Septice License   | 9   |              | 22. Name at                          | nd Address of Fa                     | acility      | moral F                     | -Iome          | РΔ                          |  |
| n ages  | a                        |          | What lake  |   |              |                                      | e P. Kal<br>Solomons                 |              |                             |                | gewater                     | , MD 21037   |
|   |                          |          | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only on   | ations that caused the dea<br>e cause on each line.       | ith. Do no   | ot enter the mod                     | le of dying, such                    | as cardiac   | or respiratory a            | arrest,        |                             | Approximate<br>Interval Between<br>Onset and Death |
| Physicia  |                          |          | Immediate Cause (Final disease or condition  | Paraspinal  | Inf          | ection                               |                                      |              |                             |                |                             | seven days   |
| /Medic<br>Examin  |                          |          | resulting in death)  | Due to (or as a conse                                     | quence o     |                                      |                                      |              |                             |                |                             |  |
|   |                          |          | Sequentially list conditions, b  | Diaphrash<br>Due to (or as a coose                        | n ta         | ralysi                               | 5                                    |              |                             |                |                             | one day  |
| ted<br>nsit   |                          |          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | 04010 (01 43 4 00000                                      | quonco o     | /-                                   |                                      |              |                             |                |                             |  |
| ou,<br>be executed<br>ician and<br>burial-transit   | 3                        | 4        | that initiated events c. resulting in death) Last  | Due to (or as a conse                                     | quence ol    | ):                                   |                                      |              |                             |                |                             |  |
| dS, F.O. BOX 68/60,  iries that the death certificate be executed signed by the attending physician and do detached for use as the burial-transit   | 3                        | S        |  |   |              |                                      |                                      |              |                             |                |                             |  |
| od<br>tiflicat<br>ig phy<br>as the  | 1                        |          |  |   |              |                                      |                                      |              |                             |                |                             |  |
| th cer<br>lendin  | 0                        |          | 230. Was decedent pregnant   | lc. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet    |              | 3 □Ectopic p                         | regnancy                             |              |                             |                | 23d. Date of de             |  |
| o death   | La Maniela de la Calenda | 200      | in the past 12 months?  1 Yes 2 No   | 4 Pregnant at time of<br>9 Unknown                        |              | 5 Other (s                           |                                      |              |                             |                | Month                       | Day Year   |
| T. D. Lat the d by the etache   | 1                        |          | 9 Unknown  |   |              |                                      |                                      | - 4.1        | ana Did                     | 1000000        |                             | a the course of death 7                            |
| THECOTICS, P.O. BOX OX The law requires that the death certificat site has been signed by the attending phy page 2 should be detached for use as the  | i                        | 2        | Part II. Other significant conditions con  | induting to death but not re                              | suiting in   | me underlying o                      | ause given in Pa                     | ап I.        |                             |                | □ No 3 □ F                  | robably 4 Unknown                                  |
| requestion of the property of | 1                        |          |  |   |              |                                      |                                      |              |                             |                |                             |  |
| 16C<br>e law<br>has t   |                          | 2.       |  |   |              |                                      |                                      |              | 24a. Was                    | DSV            | 24b. Were a prior to death? | utopsy lindings available completion of cause of   |
|   |                          |          | 25.11  |   |              |                                      |                                      |              |                             | ormed?<br>2 No | 1 □ Ye                      | s 2 No   |
| Of VICAL MEC Physician: The law rithis certificate has trail director, page 2 s   | å                        |          | 25. Was case referred to medical examiner?   | ospital: 1 Inpatient 2                                    | ☐ ER/Out     | patient 3 D                          | Other                                |              | h (Check only               |                | a Clau (a                   |  |
| - × 20  | 1 1                      | -  -     | 27. Manner of Death  | 28a. Date of Injury                                       | 28b. Ti      |                                      | 28c. Injury at<br>Work?              | Nursing Ho   | 28d. Describe               |                | 6 □Other (Spery occurred    | 9CITY)   |
| D nding   |                          |          | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year)   | In           | ury<br>M                             | Work?<br>1 ☐ Yes 2                   | 2 🗆 No       |                             |                |                             |  |
| DIVISION Jor Attending after death. Director: After   | 1919                     | 2        | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At I<br>building, etc. (Spec       | nome, lan    | n, street, lactor                    | y, office                            |              | 28I. Location<br>City or To | Street ar      | d Number or F               | lural Route Number,                                |
| ed in Digital C   | 3                        | 5        |  | Ballaling, otc. (Opec                                     | ,,           |                                      |                                      |              |                             | www.           | ·/                          |  |
| lospi<br>hount<br>uner  | . 1                      | Guicai   | 29a. Certifier Cartifying Phys   | ician: To the best of my kn<br>ar: On the basis of examin | owledge,     | death occurred                       | at the time, date                    | and place,   | and due to the              | cause(s        | and manner a                | s stated.  |
| DIVISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th compilelely filled in by the funeral   |                          |          | one)   | and manner stated.  |              |                                      |                                      |              |                             |                |                             |  |
| 7 vii   |                          | -        | 29b. Signature and title of certifier  | M -   |              |                                      | C. License numb                      |              | -                           |                | te signed (Mor              |  |
|   |                          |          | runas aystro   | ry, M-C   |              |                                      | 0315                                 | 2            |                             | Dece           | mber                        | 11,2005  |
|   |                          |          | 30. Name and address of person who con<br>Linds by Strong 1000   |   | 0            | ype, Print)                          | Baltim                               | nore         | MI                          | 212            | 97 - 9                      | 10/-   |
| 100   | State                    |          | 31. Date liled (Month, Day, Year)  | 32 Registrar's Sign                                       |              | 1100                                 | Tactiti                              | ,0,0         | 1119                        | × 126          | 31 1                        |  |
|   | istra                    |          | DEC 1 4 2005   | Deve 1  | K .          | beck                                 |                                      |              |                             |                |                             |  |

DHMH 17 Rev 1/2001

State

Registrar

32. Heristrar's Signature

1 4 2005

|               |   | 1                 | State of Maryland / Department State   | artment of Health and M<br>rtificate of Death                                     | lental Hygien<br>Reg. N                   |  |
|---------------|---|-------------------|--|---|---|--|
|               |   |                   | Registrar  Decedent's Name (First, Middle, Last)   | timoato or Boatir   | 2. Date of Death                          | 3. Time of Death                                   |
|               | Physicia  |                   |  |   | Month Da 16                               | 3:00 P <sup>M</sup>                                |
|               | /Medic  |                   | Charles Wilmer Morgan  ia. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death  |   | c. County of Death                                 |
|               | Examin  | er                | Talbot Hospice House   | Easton  |   | Talbot   |
|               | Funeral   |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | 1 1111 1 2111   | 8. Date of Birth<br>(Month, Day, Year     | Birthplace (State or Foreign                       |
| ۲             | Director  |                   | 219-01-8030 <sup>1</sup> M™ 2□F 88 Yrs.  | Months Days Flours Will.  | July 17, 1                                | M = === 1  |
|               | p.  | -                 | Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Le   | ocation   |   | 10d. Inside City Limits                            |
|               | aryla<br>show   |                   | Total State  |   |   | 1 <del>∏</del> Yes 2 □ No                          |
|               | 8a-1  | Director          | MD Talbot Easton   | 10f. Zip Code   | 10a C                                     | itizen of What Country?                            |
|               | with ti   | 吉                 | 10e. Street and Number   |   | US  |  |
|               | ss 23   | eral              | 29493 Golton Drive  11. Marital Status  12. Was Decedent Ever in U.S. 13.  | Was Decedent of Hispanic Origin? (Sp  | ecify Yes or No-                          | 14. Race - American Indian,                        |
|               | iter d  | Funeral           | Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No  | If Yes, specify Cuban, Mexican, Puerto  | Rican, etc.)                              | Black, White, etc.                                 |
| 5-0036        | filed within 72 hours after death with the Maryland<br>Hygiene.<br>Hyer than "natural", or Items 23s or 28s-f show<br>ant, the Medical Eratic or must be notified at  | þ                 | 3∑ Widowed 4 □ Divorced If Yes, Give Year or Dates:  | 1 ☐ Yes 2 X No Specify:   |   | Specify: White                                     |
| 2-0           | 72 ho<br>natur  | Completed         | (Specify only highest grade completed) (Give   | dent's Usual Occupation<br>a kind of work done during most of work                |   | Kind of Business/Industry                          |
| 2             | ithin<br>oe<br>Me   | du                | Elementary/Secondary (0-12) College (1-4or 5+)   | DO NOT use retired)   | ,   | Printing Co.                                       |
| 2             | led w<br>lygier<br>her tl   | S                 | 12 0 Phot 17. Father's Name (First, Middle, Last)  | ographer/Proofread  | e (First, Middle, Maide                   |  |
| anc           | ntal Hed of   | Be                | Charles W. Morgan  | Lucy  | Shopert                                   |  |
| Maryland 2121 | hould<br>d Me<br>mark<br>matic  | D<br>D            |  | ing Address (Street and Number or Rur   |   | or Town, State, Zip Code)                          |
| S             | nd 2 s<br>lith ar<br>27 ls  |                   | Patricia Ann Himelright/Daughter 105   | West London Avenue  | , Salisbu                                 | ry, MD 21801                                       |
| ē,            | s 1 ar<br>f Hea<br>item<br>othel  |                   | 20a. Method of Disposition 20b. Place of Disposition   |   |   | Location - City or Town, State                     |
| ê<br>E        | Page<br>ent o<br>nt: #<br>ry or   |                   | 1 V Rurial 2 Cremation 3 Removal from State !  | ill Cemetery 12/2   | 20/2005 Eas                               | ston, Maryland                                     |
| altimore,     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 271s marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ita Medical Erus, as must be notified at anony injury or other traumatic event, Ita Medical Erus. | li                | 21. Signature of Funeral Service Licensee  | 2. Name and Address of Facility   | and Norma                                 | am Europeal Homo DA                                |
| m             | Depared Important any it  |                   | JOHN R. MERCERON E   | 00 S. Harrison Sti  | eet, East                                 | on, MD 21601                                       |
|               |   |                   | 23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.  |   |   | Approximate<br>Interval Between<br>Onset and Death |
| E             | Pnysician:  |                   | Immediate Cause (Final disease or condition Metastatic   | Prostate  | (ances                                    | >2 VVS   |
|               | /Medical<br>Examiner  |                   | resulting in death)  Due to (or as a consequence of):  |   |   |  |
|               | LAGIIIIICI  | _                 | Sequentially list conditions, b. Due to for as a construence of :  |   |   |  |
|               | ted<br>nsit   | niner             | cause. Enter Underlying Cause (Disease or injury   |   |   |  |
|               | be executed<br>ician and<br>burial-transit  | Examin            | that initiated events c.  Due to (or as a consequence of):   |   |   |  |
| 8760,         | cate be executed obysician and the burial-transit   |                   | d  |   |   |  |
| 9             | tificate<br>ig phys<br>as the   | led               | The state of the s |   |   |  |
| Вох           | leath certifica<br>attending ph<br>I for use as ti  | an/N              |  | □Ectopic pregnancy  |   | 23d. Date of delivery  Month Day Year              |
|               | it the deal<br>by the att   | Physiclan/Medical | in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown   | Other (specify)   |   |  |
| P.0           | that the  | Phy               | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.   | 23e. Did tobacc                           | o use contribute to the cause of death?            |
|               | signe   | b                 | TECHEMIC Cardiamyodo   | 2+61  | 1 🗆 Yes                                   | 2 No 3 Probably 4 □Unknown                         |
| oro           | w requir<br>been si<br>should   | etec              | TO CHETTING  |   | 24a. Was an                               | 24b. Were autopsy findings available               |
| Records,      | e la<br>has   | Completed         |  |   | autopsy<br>performed                      | prior to completion of cause of death?             |
| a             |   | e Co              | 25. Was case referred to medical   | 26 Place of Dea   | 1 ☐ Yes 2 ☑<br>th (Check only one)        | No 1 ☐ Yes 2 ☐ No                                  |
| Vital         | Physician:<br>rthis certific<br>ral director,   | To Be             | examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpate   | Other   | ome 5 Residence                           | 6 on ther (Specify Hospice                         |
| o             |   |                   | 27. Manner of Death 28a. Date of Injury 28b. Time  |   | 28d. Describe how in                      | HOHEE  |
| ion           | Attending F<br>ir death.<br>ector: After<br>by the funer  | atlo              | 2 Accident investigation   | M 1 Yes 2 No  |   |  |
| Division      | or Attendate death  | Certification;    | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, set building, etc. (Specify)   | street, factory, office   | 28f. Location (Street<br>City or Town, St | and Number or Rural Route Number,<br>ate)          |
| ā             | ital or A<br>irs after<br>ral Directed in by  | Çe                |  |   |   | /- \ d   |
|               | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the  | edical            | 29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.  | ath occurred at the time, date and place investigation, in my opinion, death occu | rred at the time, date a                  | and place, and due to the cause(s)                 |
|               | thin 2<br>the of the  | Med               | 29b. Signatur and title of cert lier   | 29c. License number   | 29d.                                      | Date signed (Month, Day, Year)                     |
|               | F 3 F 8   |                   | Vaire 2/00 all VID   | D0053100  | 2 12                                      | 2/19/05  |
| ,             | 3.  |                   | 30. Name and address of person who completed cause of de \( \text{h} \) (Item 23a) (Typ  | e, Print)   |   | 1 . , 0 . 5  |
| 6             | TIVA  | 1                 | Dr. Carolyn Helmly, 508 Idlewild Ave   |   | 1601                                      |  |
|               | St  | ate               | 31. Date tiled (Nonth, Day, Year) 32. Registrar's Signature  | •   |   |  |
|               | Regist  |                   | DEO TO 5800  |   |   |  |

.0.D; 3:30 AM Maryland 21215-0036 01):12/13/05 Baltimore, P.0.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 13, 2005 **Physician** 3:30 A M HELEN LOUISE MERCER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Homewood at Crumland, Farms Frederick 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day, May 23, 9. Birthplace (State or Foreign **Funeral** 1□M 2⊠F Days Hours Maryland Director 214-10-1160 Yrs. Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 ☐ No Maryland | Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 7407 Willow Road U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō 1 ☐ Yes 2 🛂 No Specify: White 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fit and Mental H Jesse S. Fogle Agnes Lavina Pearl ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Mercer / Son 2647 Brooke Valley Road, Frederick, MD 21701 item 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State , <u>=</u> Burial 2 □ Cremation 3 □ Removal from State ò permit. Page Department of Importent: If eny injury or once. Mount Olivet Cemetery 12/16/05 Frederick, Maryland <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) ROBERT E. DATLEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter he disease, or complications that caused the dishock, or hear failure. List only one cause of each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death mmediate Cause (Final **Physician** erehours culor accident disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 12 hermids Dittool Completed 2 ENO 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2201 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09689 ritin PUTTE 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

A. Austin Pearre, Jr., MD

DEC 1 9 2005 >

31. Date filed (Month, Day, Year)

32. Registre's Signature

300 West 9th Street, Frederick, MD 21701

|  | 1           | For<br>Stata<br>Registrar   | State of                  | Marylan                                  |                                  |                          | nt of He                                   |                             | nd Me                     | _                                    | giene<br>Reg. No.        | 4 U U                    | 5                  | 423                       | 355                  |
|--|-------------|---|---------------------------|--|----------------------------------|--------------------------|--|-----------------------------|---------------------------|--------------------------------------|--------------------------|--------------------------|--------------------|---------------------------|----------------------|
| Physicia   |             | Decedent's Name (First, Middle, Las   |                           |  |                                  |                          |  |                             | 2                         | Date of De<br>Month                  | Day                      | y Ye                     | ar                 | 3. Time of                | Death                |
| /Medica  | 1           | Juana M.  | Mus                       |  |                                  | _                        |  |                             |                           | ecembe                               | _                        | 2, 200                   |                    | 1:45                      | рм                   |
| Examine  | r           | 4a. Facility Name (If not institution, give   |                           |  |                                  | 4b. Cit                  | y, Town, or                                | Location of                 | Death                     |                                      | 4c.                      | County of D              | eath               |                           |                      |
|  | •           | Montgomery Villag 5. Social Security Number 6. Se   |                           |  | Ctr.                             |                          |  | ery Vi                      |                           |                                      |                          | Montgo                   |                    | ace (State o              | - Foreign            |
| Funeral Director   |             | 1[  | _M 2 🔀 F                  | 90                                       | Yrs.                             | Month                    |  |                             | Min.                      | Date of Bin<br>(Month, Da<br>luly 1: |                          |                          | Count              | ry)                       | ii ruraigii          |
|  | -           | 220-58-5281 Usual Residence of Decedent   |                           | 90                                       |                                  |                          |  |                             |                           | iury 1.                              | 2,19                     | 1) (                     | Juba               | 1                         |                      |
| yland<br>10w   |             | 10a. State 10b. County  |                           | 10c. Cit                                 | ty, Town or Lo                   | cation                   |  |                             |                           |                                      |                          |                          | 10                 | d. Inside C               | ity Limits           |
| Mar  | jo          | Virginia Fairfax  |                           | A  | lexand                           | ria                      |  |                             |                           |                                      |                          |                          |                    | 1 🗆 Yes                   | 2 🔀 No               |
| n the  |             | 10e. Street and Number  |                           |  | 20110110                         |                          | Zip Code                                   |                             |                           |                                      | 10g. Citi                | zen of What              | t Count            | ry?                       |                      |
| th wit   |             | 6320 Gentele Court  |                           |  |                                  |                          | 22310                                      |                             |                           |                                      | U                        | SA                       |                    |                           |                      |
| dea  | _           | 11. Marital Status  | 12. Was Deced             | ent Ever in U                            | .S. 13.                          | Was Dec                  | edent of His                               | panic Origin                | n? (Specifi<br>Puerto Ric | fy Yes or No<br>can, etc.)           | -                        | 14. Race - A<br>Black, V |                    |                           |                      |
| afte afte  | 2           | 1 Never Married 2 Married   | 1 ☐ Yes 2<br>If Yes, Give |  |                                  |                          | 2 No                                       | Specify:                    |                           |                                      |                          | Specify:                 | viiito, 6          |                           |                      |
| urei',   | Sa D        | 3X Widowed 4 □ Divorced   | Year or Date              | 95:                                      |                                  |                          |  |                             |                           | -                                    |                          |                          |                    | ite                       |                      |
| "nati  | Completed   | 15. Decedent's Ed<br>(Specify only highest grad   |                           |  | (Give                            | kind of v                | ual Occupa<br>vork done di<br>use retired) | urina most o                | of working                |                                      | 16b. Ki                  | nd of Busine             | ∌ss/Ind            | ustry                     |                      |
| Mithir Inc.  | E           | Elementary/Secondary (0-12)   | College (1-4              | lor 5+)                                  |                                  |                          |  |                             |                           |                                      | 0                        | TT                       |                    |                           |                      |
| Hygie<br>ther<br>int,  |             | 10<br>17. Father's Name (First, Middle, Last)   |                           |  | Home                             | make                     |  | 18. Mother's                | s Name (                  | First, Middle,                       |                          | n Home                   | 3                  |                           |                      |
| d be intal   | Re          |   |                           |  |                                  |                          |  |                             | sefa                      | _                                    |                          | <i>-</i>                 |                    |                           |                      |
| 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or items 23a or 28a-f show surmatic event, the Medical Examinar must be notified at  | 9           | Palacio Marrei  19a. Informant's Name/Relationship (7   |                           |  | 19h Mailir                       | na Addre                 | ss (Street a                               |                             |                           | Route Numbe                          | rge                      | r Town Stat              | te Zin             | Codel                     |                      |
| d 2 s<br>d 2 s<br>th an<br>treu<br>treu  |             | Hector M. Musa  | Son                       |  |                                  | •                        | ele C                                      |                             |                           | andri                                |                          |                          |                    | 22310                     | ,                    |
| 1 and 1<br>Heelth<br>Heelth<br>Sther tr  | -           | 20a. Method of Disposition  | 2011                      | 20b. F                                   | Place of Dispo                   | sition (N                | ame of                                     | !                           | Dat                       |                                      |                          | cation - City            |                    |                           | ,                    |
| Pages<br>nent of I   |             | 1 Burial 2 Cremation 3  |                           |  | cemetery, crer<br>te of I        |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show items items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show in items 23a or 28a-1 show ite | -           | 4 Donation 5 Other (Specify   |                           |  | 22                               |                          | metery                                     | 7 De                        | ec.14                     | ,2005                                | Silv                     | er Sp                    | rin                | g,Mar                     | yland                |
| permit. Department important in in in in in in in in in in in in in  |             | 166 481   | 2                         |  | Fr                               | anci                     | s J.                                       | Collin                      | ns Fu                     | neral                                | Home                     | e, Inc                   | 2.                 | ന വര                      | 100                  |
| 1 18 1 1   | +           | 23a. Part1. Enter the disease, or comp  | lications that car        | ed the deat                              |                                  | ,                        |  |                             |                           | W.,Si                                |                          | Sprii                    |                    | Approximat                |                      |
| Physician<br>/Medical  |             | shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) | a End St                  | age Al                                   |                                  | r's                      | Disea                                      | se                          |                           |                                      |                          |                          |                    | Interval Bet<br>Onset and |                      |
| Examiner   |             |   | *                         | as a conseq                              |                                  |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
|  | e e         | if any, leading to immediate  | b. Aspira Due to (or      | tion E                                   | neumon<br>quence of):            | utis                     | 3  |                             |                           |                                      |                          | -                        | +                  |                           |                      |
| uted<br>d<br>ansit   | Examiner    | cause. Enter Underlying Cause (Disease or injury that initiated events                                |                           |  |                                  |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
| icate be executed physician and s the burial-transit   | LX          | resulting in death) Last  | Due to (or                | as a conseq                              | quence of):                      |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
| ysicia<br>ysicia   | dical       | (   | d                         |  |                                  |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
|  | •           | IC CEMALE.  |                           |  |                                  |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
| Physician: The law requires that the death certifical this certificate has been signed by the attending phart director, page 2 should be detached for use as the certificate has been signed by the attending phart director, page 2 should be detached for use as the certificate and the certificate as the certificate and the cert | Physician/M | 23b. was decedent pregnant  | 23c. If yes, outco        | me of pregna                             |                                  | Ectopic                  | pregnancy                                  |                             |                           |                                      | 2                        | 23d. Date of             |                    |                           |                      |
| s dea<br>he at<br>he d fo  | 2           | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 4□Pregnar<br>9□ Unknow    | nt at time of d                          |                                  | Other (                  |  |                             |                           |                                      |                          | Month                    | į                  | Day `                     | Year                 |
| at the lby ti  | ב           | 9 Unknown   |                           |  |                                  |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
| res that the de signed by the a lbe detached f   | ^           | Part II. Other significant conditions co  | ntnbuting to dea          | th but not res                           | sulting in the u                 | nderlying                | cause give                                 | n in Part I.                |                           |                                      |                          | se contribut             |                    |                           |                      |
| w require been si should I   | ed          |   |                           |  |                                  |                          |  |                             | _                         | 10                                   | /es 2[                   | XNO 3                    | Proba              | ibly 4 🗆                  | Juknown              |
| has by ge 2 st   | Complete    |   |                           |  |                                  |                          |  |                             |                           | 24a. Was                             | SV                       | 24b. Were                | autop              | sy findings               | available<br>ause of |
| The The page   | 0           |   |                           |  |                                  |                          |  |                             |                           | perfo<br>1 ☐ Yes                     | rmed?                    | death                    |                    | 2□ No                     |                      |
| sian:<br>entific<br>ector,   | D D         | 25. Was case referred to medical examiner?  |                           |  |                                  |                          |  |                             | of Death (                | Check only o                         | ne)                      |                          |                    |                           |                      |
| ding Physician: The In. h. After this certificate he funeral director, page  | 2           | 1 ☐ Yes 2 X No  | Hospital: 1 🗆 Int         | patient 2                                | ER/Outpatier                     | nt 3 🗆 I                 |  | 4 K Nurs                    | ing Home                  | 5 Resid                              | dence 6                  | Other (S                 | Specify,           | )                         |                      |
| ing P  | 20          | 27. Manner of Death 1   Natural 5 □ Pending   | 28a. Date of<br>(Month,   | Injury<br>Day Year)                      | 28b. Time of<br>Injury           |                          | 28c. Injury<br>Work                        |                             |                           | d. Describe !                        | now injur                | y occurred               |                    |                           |                      |
| eath.  | cat         | 2 Accident investigation 3 Suicide 6 Could not be   |                           |  |                                  | М                        |  | es 2 No                     |                           |                                      |                          |                          |                    |                           |                      |
| or Attenosite deatl  | ertificati  | 4 Homicide determined   | 28e. Place o<br>building  | f Injury - At h<br>, etc. <i>(Specil</i> | ome, farm, str<br>fy)            | reet, facto              | ory, office                                |                             | 28                        | f. Location (S<br>City or Tox        | Street and<br>vn, State, | d Number oi<br>)         | r Rurai            | Route Num                 | ber,                 |
| To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affei completely filled in by the fune  | ر د         | 00-0-45   |                           |  |                                  |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |
| To the Hospital within 24 hours e To the Funerel I completely filled   | Medical     | 29a. Certifier 1 ☑ Certifying Phy<br>(Check only 2 ☐ Medical Exam                                     | iner: On the bas          | is of examina                            | owledge, deat<br>ation and/or in | h occurre<br>vestigation | ed at the time<br>on, in my op             | e, date and<br>inion, death | place, and<br>occurred    | d due to the at the time.            | cause(s)<br>date and     | and manne<br>place, and  | r as sta<br>due to | ited.<br>the cause(s      | ;)                   |
| thin 2<br>thin 2<br>the<br>mplei   | Med         | 29b. Signature and title of certifier   | and manne                 | r Stated.                                |                                  | 10                       | 9c. License                                | number                      |                           |                                      | 29d Date                 | e signed (M              | lonth f            | av Vaari                  |                      |
| T W T O  | -           | 250. Organization of Controls   | Mal.                      | Z  | 117                              |                          |  |                             |                           |                                      | Lou. Dali                | o signed (M              | Juli L             | ruy, IEdi)                |                      |
| 4  |             | inun,   | nay                       | 121                                      | ND                               |                          | 5642                                       | 8                           |                           | Þ                                    | ecem                     | ber 13                   | 3, 2               | 2005                      |                      |
|  |             | 30. Name and address of person who o  |                           |  |                                  |                          | ъ .  | _                           |                           |                                      | · C                      | 000=-                    |                    |                           |                      |
| State  |             | Humera E. Malik, I<br>31. Date filed (Month, Day, Year)   | 1. D.                     | 195<br>gistrar's Signa                   | 19 Doc                           | tors                     | Driv                                       | e Ger                       | rmant                     | own,                                 |                          | 20876                    |                    |                           |                      |
| Registra   |             | DEC 1 5 200   |                           | H  | 6084                             |                          |  |                             |                           |                                      |                          |                          |                    |                           |                      |

|                     |  | •             | For<br>1 - Stata<br>Registrar   | State of M  | aryland / D                     | epartment of<br>Certificate o                  | Health and                             | d Mental Hyg   | •  | 5 4235   |  |  |  |
|---------------------|--|---------------|---|---|---------------------------------|--|--|--|--|--|--|--|--|
| 9                   | \$   |               | Decedent's Name (First, Middle, L.  | ast)  |                                 |  |  | 2. Date of Dea   | th   | 3. Time of Death                                 |  |  |  |
|                     | Physici  |               | Marie E. Megl   | es  |                                 |  |  | Decemb   | December 12, 2005 1                              |  |  |  |  |
| V .                 | /Medic<br>Examin   | _             | 4a. Facility Name (If not institution, gi   | ve street and number)                                 |                                 | 4b. City, Town                                 | , or Location of De                    |  | 4c. County of Deat                               |  |  |  |  |
|                     |  | 33            | Manor Care- Che   | vy Chase  |                                 | Chevy  | Chase                                  |  | Montgo   | omery  |  |  |  |
| 2.                  | - Funeral  |               | ,   |   | ge (In yrs. last birt           | Months Day                                     | ar If Under 24 h                       | Hrs. 8. Date of Birth<br>Min. (Month, Day  | year) 9. Birt                                    | hplace (State or Foreign                         |  |  |  |
|                     | Director   |               | 191-01-5481   | 1 □ M 28 □ F  | 96                              | rs.  |  | Sept. 2  | 9, 1909 H  | ungary   |  |  |  |
|                     | pue M  |               | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town                 | or Location                                    |  |  |  | 10d. Inside City Limits                          |  |  |  |
|                     | Maryli<br>e ho   | ក             |   | dams  |                                 |  |  |  |  | 1 Yes 2 No                                       |  |  |  |
|                     | the A  | Directo       | Pennsylvania A  10e. Street and Number  | uallis  | Fa1                             | rfield  10f. Zip Code                          | 3                                      | 1  | Og. Citizen of What Co                           | nuntar?  |  |  |  |
|                     | With<br>Be or  |               | 14 Hillview Cour  | +   |                                 | 15425  |  | '  | USA  | , array .  |  |  |  |
|                     | me 2%  | Funerai       | 11. Marital Status  | 12. Was Decedent                                      | Ever in U.S.                    |  |  | ? (Specify Yes or No-<br>uerto Rican, etc.)  |  |  |  |  |  |
| 20                  | or Ite   | Für           | 1 ☐ Never Married 2 ☐ Married   | Armed Forces?   |                                 |  |  | uerto Rican, etc.)   |  |  |  |  |  |
| 8                   | be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or iteme 23a or 28a-f ehow event, the M. circal Examiner must be putilled at | by            | 3 ₩ Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:                        |                                 | 1 ☐ Yes 🏗 ☐ N                                  | lo Specify:                            |  | Specify: Wh:                                     | ıte  |  |  |  |
| Maryland 21215-0036 | 72 hc  | Completed     | 15. Decedent's E<br>(Specify only highest g   | Education<br>rade completed)                          | 16a.                            | Decedent's Usual Occ<br>(Give kind of work dor | cupation<br>ne during most of          | working  | 16b. Kind of Business                            | /Industry  |  |  |  |
| 7                   | within 72<br>ene.<br>than "nat   | npi           | Elementary/Secondary (0-12)   | College (1-4or  |                                 | life. DO NOT use reti                          | ired)                                  |  |  |  |  |  |  |
| 2                   | filed w<br>Hygier<br>other th  |               |   | 2   | H                               | omemaker                                       | 1                                      |  |  | Home   |  |  |  |
| and<br>and          | be fi  | Be            | 17. Father's Name (First, Middle, Las   | (t)   |                                 |  |  | Name (First, Middle,   | Maiden Sumame)                                   |  |  |  |  |
| $\frac{8}{2}$       | should be land Mental le marked o  | J.            | Michael Megles  | (Time Driet)  | 101                             | M-T- Att                                       |  | Gazlett  | 0" T 0"  | 7.0.11   |  |  |  |
| <u>a</u>            | 12 sh<br>h and<br>7 le n<br>traun  |               | 19a. Informant's Name/Relationship  Judy DiGioia/ N   |   | 190.                            |  |  |  | r, City or Town, State, 2000, MD 2089            | '  |  |  |  |
| e,                  | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If Itam 27 Ie marked<br>eny Injery or other traumatic ev                                 |               | 20a. Method of Disposition  |   | 20b. Place of                   | Disposition (Name of                           | ru nouu,                               |  | 20c. Location - City or                          |  |  |  |  |
| Baltimore,          | H H  |               | 1 □ Burial 2 □ Cremation 3y   |   | cemeter                         | y, crematory or other p                        | place) De                              | cember 16  |  |  |  |  |  |
| 를                   | ritme rit  |               | 4 □Donation 5 □ Other (Spec<br>21. Signal up of Funeral Service Lice                                |   | Mt. St                          | . Macrina                                      | drace of English                       |  | Uniontown, Pe                                    | nnsylvania                                       |  |  |  |
| B                   | perm<br>Depa<br>Impo<br>eny i  |               | 21. Signature of Full of a Color  | X ./ -  |                                 | Francis J.                                     | Collins F                              | uneral Home  | Inc  | 03   |  |  |  |
| B                   | 45   |               | 23a. Part1. Enter the discusse, or con  | nolications that cause                                | d the death. Do n               |  |  | The second secon | pring, Mu 209                                    | Approximate                                      |  |  |  |
|                     |  |               | shock, or heart failure. List ont<br>Immediate Cause (Final   | y one cause on each I                                 | ine.                            |  | , 3.                                   | ,,   |  | Interval Between<br>Onset and Death              |  |  |  |
| 1                   | Physician /<br>/Medical  |               | disease or condition resulting in death)  | a. Pneumon  |                                 |  |  |  |  |  |  |  |  |
| 7 7                 | Examiner   |               |   | Due to (or as   | a consequence                   | ot):   |  |  |  |  |  |  |  |
| 243                 |  | er            | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as                                      | a consequence                   | of):   |  |  |  |  |  |  |  |
|                     | be executed<br>sicien and<br>burial-transit  | Examiner      | if any, leading to immediate cause Eter U cuty c Cause (Disease or injury that initiated events  c. |   |                                 |  |  |  |  |  |  |  |  |
| Ć.                  | be executed<br>icien and<br>burial-transit   | Еха           | resulting in death) Last  | Due to (or as   | a consequence                   | of):   |  |  |  |  |  |  |  |
| 760,                | <u>a</u> 2 a   | cai           |   | d   |                                 |  |  |  |  |  |  |  |  |
| 9                   |  | ledi          |   |   |                                 |  |  |  |  |  |  |  |  |
| Box                 | requires that the death certifical seen signed by the attending phy hould be detached for use as the   | Physician/Med | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome                                  | of pregnancy<br>2 Petal death   | 3 ⊟Ectopic pregna                              | ncv                                    |  | 23d. Date of de                                  | ,  |  |  |  |
|                     | deat   | sicie         | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Pregnant a  |                                 | 5 Other (specify)                              |  |  | Month  | Day Year   |  |  |  |
| <u>Р</u><br>О       | at the   | hy            | 9 Unknown   |   |                                 |  |  |  |  |  |  |  |  |
|                     | es th<br>igned   | by            | Part II. Other significant conditions   | contributing to death t                               | out not resulting in            | the underlying cause                           | given in Part I.                       |  | bacco use contribute to                          |  |  |  |  |
| מ                   | w require<br>been signal   |               |   | _ 1 O Y   | 1 Yes 2 No 3 Probably 4 Unknown |  |  |  |  |  |  |  |  |
| Records,            | law<br>as b  | pie           |   |   |                                 |  |  | 24a. Was a autop:  |  | utopsy findings available completion of cause of |  |  |  |
| <u>~</u>            |  | Completed     |   |   |                                 |  |  | perfor<br>1 ☐ Yes  | med? death?                                      | 2 □ No   |  |  |  |
| Vita                | ician: Th<br>certificate<br>ector, pag   | Be            | 25. Was case referred to medical examiner?  |   |                                 |  |  | Death Check only or  | 78/  |  |  |  |  |
|                     | hysi<br>this c   | မ             | 1 ☐ Yes 2 🛣 No  | Hospital: 1 Inpati<br>28a. Date of Inju<br>(Month, Da | ent 2 ER/Ou                     |  | Other: 4 X Nursin<br>njury at<br>Vork? |  | ence 6 □Other (Spe                               | cify)  |  |  |  |
| Division of         | Attending Physician: r death. ector: After this certific by the funeral director.  | ertification: | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28d. Describe h                                       | Describe how injury occurred    |  |  |  |  |  |  |  |  |
| S                   | r Attender death   | cat           | 2 Accident Investigati 3 Suicide 6 Could not  | he -  | AA baara 4-                     |  | Yes 2 No                               | not be action (C   |  |  |  |  |  |
| $\leq$              | or Atter of Direction by   | artif         | 4 Homicide determine  | d 286. Place of in<br>building, e                     | tc. (Special)                   | rm, street, factory, offic                     | ce                                     | City or Tow  | treet and Number or Ri<br>n, State)              | urai Houte Number,                               |  |  |  |
| _                   | To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director; completely filled in by the  | O             | 29a. Certifier 1 Certifying   | hyeicies. To the hear                                 | of my kn stad                   | doath convert at "                             | time date d                            | land and due to the  | ause(s) and manner as                            |  |  |  |  |
|                     | Hos<br>24 hc<br>Fun<br>stely   | edical        | (Check only 2   Medical Ext   | iminer: On the basis of and manner si                 | of examination an               | d/or investigation, in m                       | y opinion, death o                     | occurred at the time, o  | ause(s) and manner as<br>late and place, and due | s stated.<br>e to the cause(s)                   |  |  |  |
|                     | To the within 2 To the complet   | Me            | 29b. Signature and title of certifier   | a   | -                               | 29c. Lice                                      | ense number                            | 2  | 29d. Date signed (Mont                           | h, Day, Year)                                    |  |  |  |
|                     | ⊢ <b>≯</b> ⊢ ŏ   |               | <b>\</b>  | / _ /   | ( )                             | 1  | 00512                                  |  | December 1                                       |  |  |  |  |
| •                   | lo   |               | 30. Name and address of person who  | o completed rause of                                  | death (Item 23a)                |  | 005 12                                 |  |  |  |  |  |  |
|                     | 4  |               | Anushiravan Dadg  |   |                                 |  | r Drive,                               | #201, Roo  | ckville, MI                                      | 20850  |  |  |  |
| 1                   | Sta  | ite           | 31. Date filed (Month, Day, Year)   |   | rar's Signature                 | land B   |  |  |  |  |  |  |  |
| Ł                   | Regist   |               | <b>DEC</b> 1 5 20   | 05  | rar's Signature                 |  |  |  |  |  |  |  |  |
|                     |  |               |   |   |                                 |  |  |  |  |  |  |  |  |

DHMH 17 Rev 1/2001

|          |  |                                       | For<br>State<br>Registrar  | State o                  | f Marylar        |                             | partment of H<br>ertificate of L                              |   |  | iene<br>g. No. 005                        | 42357                             |  |  |
|----------|--|---------------------------------------|--|--------------------------|------------------|-----------------------------|---|---|--|---|-----------------------------------|--|--|
|          |  | Decedent's Name (First, Middle, Last) |  |                          |                  |                             |   |   | 2. Date of Death                         | h   | 3. Time of Death                  |  |  |
|          | Physicia   |                                       | Jeannine Delores MI  |                          |                  |                             | R   |   | Month 12                                 | Day Ye.                                   | - / / e - 1 M                     |  |  |
|          | /Medic<br>Examin   |                                       | 4a. Facility Name (If not institution,   |                          |                  |                             |   | Location of Death                           | 12                                       | 16 20<br>4c. County of D                  |                                   |  |  |
|          | Examin   | er                                    | 17934 Garden La  |                          |                  | 2                           |   | rstown, M                                   | farvland                                 | Washi                                     |                                   |  |  |
|          | C  |                                       |  | i. Sex                   | 7. Age (In yrs.  |                             |   | If Under 24 Hrs.                            | 8 Date of Birth                          |   | Birthplace (State or Foreign      |  |  |
|          | Funeral<br>Director  |                                       | 214-30-2095  | 1 □ M 2🖸 F               |                  | 76 Yrs.                     | Months Days   | Hours Min.                                  | (Month, Day, Aug. 13,                    | rear)                                     | Country) Maryland                 |  |  |
|          |  |                                       | Usual Residence of Decedent  |                          |                  |                             |   |   | Aug. 13,                                 | 1229                                      | Maryrand                          |  |  |
|          | ow ow  |                                       | 10a. State 10b. County   |                          | 10c. Ci          | ty, Town or                 | Location  |   |  |   | 10d. Inside City Limits           |  |  |
|          | Man<br>feet  | ţō                                    | Maryland Wash  | ington                   | Нар              | ersto                       | νn  |   |  |   | 1 ☐ Yes 2X No                     |  |  |
|          | 28a  | rec                                   | 10e. Street and Number   | 800                      | 11.008           | CIDCO                       | 10f. Zip Code   |   | 10                                       | g. Citizen of What                        | Country?                          |  |  |
|          | 3a or  | Funeral Director                      | 17934 Garden La  | ane Ants                 | Ant              | 2                           | 21.   | 740   |  | U.S.                                      |                                   |  |  |
|          | ns 2:  | era                                   | 11. Marital Status   | 12. Was Dec              | edent Ever in U  |                             |   |   | ecify Yes or No-                         | 14. Race - A                              | merican Indian.                   |  |  |
|          | fter of the ritter   | F                                     | 1 X Never Married 2 ☐ Marrie   | Armed Fo<br>d 1 ☐ Yes    |                  |                             | <ol><li>Was Decedent of Hi<br/>If Yes, specify Cuba</li></ol> | n, Mexican, Puerto                          | Rican, etc.)                             |   | /hite, etc.                       |  |  |
| ž        | II. ou   | by                                    | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Gir<br>Year or D | ve               |                             | 1 ☐ Yes 21 No   | Specify:                                    |  | Specify:                                  | white                             |  |  |
| វ        | tura<br>atura  |                                       | 15. Decedent's   |                          |                  | 16a. De                     | cedent's Usual Occupa   | ation                                       | 1 1                                      | 16b. Kind of Busine                       | ess/Industry                      |  |  |
| 2        | in 7   | Completed                             | (Specify only highest  |                          | 1 4 5 - 3        | (Gi<br>life                 | ve kind of work done of . DO NOT use retired,                 | luring most of work<br>)                    | ing                                      |   | ,                                 |  |  |
| 7        | with<br>lene.<br>thau  | m <sub>o</sub>                        | Elementary/Secondary (0-12) 0-12   | College (                | 1-40r5+)         | ac                          | countant  |   |  | federal                                   | government                        |  |  |
| 5        | Hyg<br>Hyg<br>othar  | Ö                                     | 17. Father's Name (First, Middle, La   | ist)                     |                  |                             |   | 18. Mother's Name                           | e (First, Middle, M                      |   | 801022                            |  |  |
| 8        | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. The same and Mental Hygiene in the Medical Examination of the marked other than "natural", or transation as a per milliand at other traumatic evant, the Medical Examinations as the milliand at | 00                                    | Charle   | s H.H. M                 | iller            |                             |   |   |  | L. Mill                                   | er                                |  |  |
| >        | hould d Me   | 은                                     | 19a. Informant's Name/Relationshi  | Type Print)              |                  | 19h Ma                      | uling Address (Street   | and Number or Pur                           |  | aber, City or Town, State, Zip Code)      |                                   |  |  |
| 200      | d 2 s<br>th an<br>7 is   |                                       | Joanne Sowers  |                          |                  |                             |   |   |  |   |                                   |  |  |
| ני       | 1 and<br>Health<br>em 27<br>thar tr  |                                       | 20a. Method of Disposition   | SISTEL                   | 20b. l           |                             | position (Name of   |   |  | 20c. Location - City                      | ryland 21740                      |  |  |
| 5        | Pages<br>nent of P<br>ant: If it   |                                       | 1 ☑ Burial 2 ☐ Cremation 3   |                          | State            | cemetery, c                 | rematory or other place                                       | Decem                                       | ber                                      |   |                                   |  |  |
|          | tant:  |                                       | '4 □Donation 5 □ Other (Spe  |                          | Ced              | dar La                      | awn Mem.Par   | , 419                                       |  |   | wn, Maryland                      |  |  |
| Dallillo | permit. Pages<br>Department of<br>Important: If it<br>any injury or o  |                                       | 21. Signature of Funeral Service Li  | censee                   |                  |                             | 22. Name and Addres   |   |  | FUNERAL                                   |                                   |  |  |
| _        | <u>~</u> 0 = e ol  |                                       | fred L. Vista 415 E. Wilson Blvd., Hagerstown, Md. 21740   |                          |                  |                             |   |   |  |   |                                   |  |  |
|          |  |                                       | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between |                          |                  |                             |   |   |  |   |                                   |  |  |
|          | Physician<br>/Medical  |                                       | Immediate Cause (Final disease or condition  | BC07                     | F 41400          | 44714                       | ( INFAMC  | 700 0                                       |  |   | Onset and Death                   |  |  |
|          |  |                                       | resulting in death)  | Due to                   | (or as a consec  | uence of):                  | Chil  | 1)00, 3                                     | CL PAC 16                                | •\$                                       | 300000                            |  |  |
|          | Examiner   |                                       | Sequentially list conditions   | b                        |                  |                             |   |   |  |   |                                   |  |  |
| _        | n =  | Examiner                              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   |                          |                  |                             |   |   |  |   |                                   |  |  |
|          | cutec  | mi                                    | Cause (Disease or injury that initiated events   | C                        |                  |                             |   |   |  |   |                                   |  |  |
| ĵ.       | an ar<br>rial-t  | EX                                    | resulting in death) Last Due to (or as a consequence of):  |                          |                  |                             |   |   |  |   |                                   |  |  |
| 0000     | icate be executed<br>physician and<br>the burial-transit   | dical                                 |  | d                        |                  |                             |   |   |  |   |                                   |  |  |
| 0        |  | (D)                                   |  | 100                      |                  |                             |   |   |  |   |                                   |  |  |
| Š        | death certifica<br>s attending pl  | N/N                                   | IF FEMALE:<br>23b. Was decedent pregnant   |                          | tcome of pregn   |                             | л П <b>с</b>  |   |  | 23d. Date of                              | delivery                          |  |  |
| ٥        | death<br>e atte<br>d for   | Cla                                   | in the past 12 months 4 Pregnant at time of death 5 Other (specify)  |                          |                  |                             |   |   |  | Month                                     | onth Day Year                     |  |  |
| )        | The law requires that the death certifite has been signed by the attending age 2 should be detached for use as   | Physician/M                           | 9 Unknown  | 9□Unkn                   | own              |                             |   |   |  |   |                                   |  |  |
|          | than<br>ned is<br>det  | by P                                  | Part II. Other significant condition   | s contributing to d      | eath but not res | sulting in the              | underlying cause give   | en in Part I.                               | 23e. Did tob                             | acco use contribut                        | e to the cause of death?          |  |  |
| cords,   | quire;<br>n sig<br>nd bu   |                                       |  |                          |                  |                             |   |   | 1 ☐ Ye                                   | s 2 10 3                                  | Probably 4 Unknown                |  |  |
| 2        | w require<br>been signature  | Completed                             |  |                          |                  |                             |   |   | 24a. Was an                              | 24h Were                                  | autopsy findings available        |  |  |
| E<br>E   | he la<br>s has<br>ge 2   | m                                     |  |                          |                  |                             |   |   | autopsy                                  | / prior                                   | to completion of cause of         |  |  |
| 0        | n: TI<br>licate<br>r, pa   |                                       | 00.14  |                          |                  |                             |   |   | 1 ☐ Yes 2                                | 101                                       | /es 2□No                          |  |  |
| VIE      | sicial<br>certii<br>recto  | Be                                    | 25. Was case referred to medical examiner:   | Hospital:                |                  |                             | Othe  | 26. Place of Deat                           |  |   |                                   |  |  |
| 5        | Phys<br>this<br>ral di   | . To                                  | 1 Pres 2 No 27. Manne of Death   | 28a. Date                |                  | ER/Outpat<br>28b. Time      |   | 4 □ Nursing Ho                              | me 5 Resider<br>28d. Describe hor        | nce 6 Other (S                            | Specify)                          |  |  |
|          | fing<br>After<br>fune  | lo                                    | 1 Watural 5 ☐ Pending  | (Mon                     | th, Day Year)    | Injun                       | y Work  | res 2 □ No                                  | 200. Describe no                         | w injury occurred                         |                                   |  |  |
| Slon     | ttenc<br>death<br>rtor:<br>the   | cat                                   | 2 Accident investiga 3 Suicide 6 Could no  | t he                     | f Indiana - A h  |                             |   |   | 79f Lanatina (Cta                        |   | 2 12 14                           |  |  |
| $\geq$   | or A   | Certification;                        | 4 Homicide determin  | ed 280. Place<br>build   | ing, etc. (Speci | ome, tarm,<br>fy)           | street, factory, office                                       |   | City or Town,                            | eet and ivumber or<br>, State)            | Rural Route Number,               |  |  |
|          | pital<br>purs a<br>eral  |                                       | 29a. Certifier 1 Certifying  | Dhusisian T. th          |                  |                             |   |   |  |   |                                   |  |  |
|          | Hos<br>24 ho<br>Fun<br>tely t  | edical                                | (Check only 2 Medicel E  | kaminer: On the b        | asis of examina  | owiedge, de<br>ation and/or | eath occurred at the tim<br>investigation, in my op           | ie, date and place,<br>pinion, death occuri | and due to the ca<br>red at the time, da | use(s) and manner<br>ite and place, and c | as stated.<br>due to the cause(s) |  |  |
|          | To the Hospital or Attending Physician: The law within 24 bours after death.  To the Funeral Director Atter this certificate has completely filled in by the funeral director, page 2  | Mec                                   | 29b. Signature and title of certifier  |                          | ner stated.      |                             | 29c. License  | number                                      | 29                                       | d. Date signed (M                         | onth, Day, Year)                  |  |  |
| ı        | F ≱ F 8  |                                       | 1 m  |                          |                  | _                           |   |   | 1.                                       | ) / /                                     |                                   |  |  |
|          |  |                                       | pu ////  | ho completed             | - M              | <u>D</u>                    | 1000  | 1040  | 1/2                                      | - 16 -                                    | 1006                              |  |  |
| śμ       | -6   |                                       | 30. Name and address of person w   | 22. L                    | or death (Iter   | п 23а) (Тур                 | e, Print)   | ACTR.                                       | 14 / 111                                 | 217                                       | 40                                |  |  |
|          | Sta  | to                                    | 31. Date filed (Months Days Year)  | 000= 32.6                | Registrar's Sign | ature                       | 711/11/1  |   | y me                                     |   |                                   |  |  |
|          | Registr  |                                       | DEC 19   | 2005                     | Green            | D. 1                        | DOOD P. Print)  ST., HA                                       |   |  |   |                                   |  |  |
|          |  |                                       |  |                          |                  |                             |   |   |  |   |                                   |  |  |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dec 10 2005 **Physician** 1704 Massey Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year II Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Days 423-26-4262 78 Director Sept. 13 1927 Alabama Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Exarct or must be notified at Maryland Calvert Port Republic 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4050 Hance Road 20676 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Ite 1 to Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 43-63 1 ☐ Yes 2√2 No Specify: Speciphite þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th deep sea diver/welder US Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Yancey Moore Lemma Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Link-daughter 4050 Hance Rd. Port Republic MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages ' Department of t Important: If ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Southern Memorial Gardens Dec 14 2005 Dunkirk Maryland 22. Name and Address of Facility 21. Signature of Fucural Service Licensee Rausch Funeral Home 4405 Broomes is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Infarction Physician /Medical Due to (or as a consequence of) Examiner Coronal A.te Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) the 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been signal Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes ☑ No 24a. Was an autopsy performed? page certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 2 ☐ ER/Outpatient 35 DOA funeral dir After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 Tyes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 🛩 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 247(10 PRINCE FREderick, MD 30. Name and address of person completed cause of death (tem 23a) (Type, Print) 110 HOSPITAL 32. Registra Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 11:05 a M Charles Michaud December 6, 2005 James /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Lusby Calvert 11417 Redlands Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Yrs. Nov 4, Director 008-10-2797 84 Vermont Usual Residence of Decedent with the Maryland show. 10c. City, Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11417 Redlands Road 20657 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Myes 2 No If Yes, Give Year or Dates: 1943 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 sales representative corporate retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michaud Maude Charles Joseph Daisy Guyette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20657 Irene Michaud, wife 11417 Redlands Rd., Lusby, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 12-12-2005 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Arrhythmia. **Physician** 5 minutes /Medical Examiner Atheroscierohic Cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š Stage Renal 1 Yes 2 No 3 Probably 4 ⊡Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Congos brue Heart 24a. Was an autopsy performed? Ascites 1 Yes 2 No 1 Yes 2 PNo Division of Vital 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Pis After this funeral of 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28a. Date of fnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 ☐ Yes 2 ☐ No nours after death neral Director: / filled in by the f 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 50653 - ana. 12-6-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN . C. SURAN A Deale Deale Munchton Road. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC - 9 2005 Registrar

|   | :  |                | 1 - For<br>State<br>Registrar   | State of Ma   | arylan                           |  | rtment<br>tificate                                       |                                   |   | d Mental H                               | lygien<br>Reg. N   | 201                                       | 05                                       | 42360   | 0 |
|---|--|----------------|---|---|----------------------------------|--|--|-----------------------------------|---|--|--|---|--|---|---|
|   | Physici<br>/Medio  |                | 1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day DATE LEON MIMFORD  2. Date of Death Month Day  |   |                                  |  |  |                                   |   |  |  | Year<br>005                               | 3. Time of Death 0325                    | 1   |   |
|   | Examir   |                | 4a. Facility Name (If not institution, given ATLANTIC GENERAL   |   |                                  |  |  | Town, or RLIN                     | Location of D                               | eath                                     | 1  | c. County of                              |  |   |   |
|   | Funeral<br>Director  |                | 5. Social Security Number 218-12-1226   | Sex 7: Ag   | e (In yrs. I                     | ast birthday)<br>Yrs.                  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min. |                                   |   | Birth<br>Day, Yea                        | 9. Birthpla<br>Count<br>1925 MARY                                  |   | lace (State or Foreign<br>stry)<br>YLAND | ח   |   |
|   | aryland<br>•how  | 10             | Usual Residence of Decedent  10a. State 10b. County   |   |                                  | , Town or Loc                          |  |                                   |   |  |  |   | 1  | 0d. Inside City Limits                        |   |
|   | death with the Maryland<br>ms 23a or 28e-f ehow<br>rrivet be mullied at  | al Director    | DE SUSSEX  10e. Street and Number  RD 3 BOX 292B  |   | FENV                             | VICK IS                                | 10f. Zip   | Code<br>19944                     | <b>4</b>                                    |  | 10g. C   | Citizen of W                              | haf Coun                                 |   | _ |
| 98  | a 2 9  | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent<br>Armed Forces?<br>1 X Yes 2 1<br>If Yes, Give                                  | No                               | If                                     | Vas Deced<br>Yes, spec                                   | ify Cubar                         | spanic Origin?<br>, Mexican, Pi<br>Specify: | (Specify Yes or<br>uerto Rican, etc.)    | No-  |   | · Americ<br>c, White,                    |   |   |
| 12/05<br>325<br>21215-0036  | 27   | Completed b    | 15. Decedent's E  | 5. Decedent's Education only highest grade completed)  16a. Decedent's (Give kind of life, DO No. |                                  |  |  |                                   |   |  |  |   |  | dustry PRODUCTS                               |   |
| _   | should be filed within the Mental Hygiene. marked other then matic event.  | To Be C        | 17. Father's Name (First, Middle, Last<br>ISAIAH C. MUMF  |   |                                  |  |  |                                   |   | Name (First, Midd<br>VA K. HEA           |  | n Sumame                                  | 3)                                       |   |   |
| To O  | is 1 and 2 should<br>of Heelth and Mer<br>Item 27 le marke<br>other traumatic  |                | 19a. Informant's Name/Relationship HELENA C. MUMFOR   |   | 1                                | RD 3                                   | BOX 2  | 292В,                             |   | CK ISLA                                  | ND, I  |   |  |   |   |
| DOD - 727<br>O  | permit. Pages 1<br>Department of He<br>Important: If Iter<br>any Injury or oth   |                | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci  | fy)   | a                                | lace of Disposemetery, crem<br>SHOPVIL | LE CI  | ther place<br>EMETI               | ERY 12                                      | Date 17/05                               |  | HOPV                                      | ,  |   |   |
|   | Departit<br>Departit<br>Import   |                | 21. Signature of Jun ral Syrvice Lice   | Hort  | _                                | HA                                     | STING  | GS FU                             |   | HOME, SI                                 |  | ILLE,                                     | DE                                       | A   |   |
| 27.7  | Physician<br>/Medical  |                | 23a. Part1. Fiter the disease, or con<br>shock, or heart faifure. List only<br>firmediate Cause (Final<br>disease or condition<br>resulting in death)   | one cause on soph   | 500                              |  | 5.0  |                                   |   |  |  |   |  | Approximate finterval Between Onset and Death |   |
| 1 2 1 - 1 - 1 2 1 - 1 2 1 1 1 1 1 1 1 1   | Examiner and transit   | dicai Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. Due to (or as  C. Due to (or as  d.  |                                  |  | tric   | tive                              | Ruh   | Miring                                   | Dis  | Cerre                                     |  | Yes.  |   |
|   | the death certifi<br>y the attending p<br>ched for use as  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No 9 ☐ Unknown  | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown                           | 2 Feta                           | Ideath 3                               | Ectopic pro  |                                   |   |  |  | 23d. Date<br>Mon                          |  | ory<br>Day Year                               |   |
| ه وي  | quires that<br>in signed b   | þ              | art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco   |   |                                  |  |  |                                   |   |  | co use contribute to the cause of death? 2 No 3 Probably 4 Unknown |   |  | 1   |   |
| n tord<br>12 - 1920<br>ital Becord  |  | Completed      |   |   |                                  |  |  |                                   |   | pe<br>1 ☐ Yes                            | itopsy<br>erformed?<br>s (350)                                     | d d                                       | /ere autoprior to coreath?               | psy findings available inpletion of cause of  | • |
| 2 ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~   | After th   | ation: To Be   | examiner?  1  |   |                                  |  |  |                                   |   |  |  | r)  |  |   |   |
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|   | To the Hospital within 24 hours a To the Funeral is bompletely filled  | Medical        | one)  | hysician: To the best<br>miner: On the basis o<br>and manner st                                   | of my kno<br>of examina<br>ated. | wledge, death<br>tion and/or inv       |  | at the tim<br>in my op<br>License |   | ace, and due to t<br>eccurred at the tim |  | (s) and mar<br>nd place, a<br>Date signed |  |   |   |
| •   | Constitution of the consti |                | 29b. Signature and the of section   | recolul   | - 6                              | 4                                      | _ 1  | 02                                | 876   | 9  | /  | 26  | dos                                      |   |   |
|   | 7.3  |                | Name and address of person who was a second of the second | Books 32. Registr   | ulie                             | , us                                   | Print)   | 09                                | Conta                                       | A Heghe                                  | y F  | -<br>teui                                 | よる                                       | (Dé 9741                                      | ł |
|   | St:<br>Regist  | ate<br>rar     | DEU 1 5   | 2005  | West .                           | H. K                                   | sail   | J.                                |   | 7  |  |   |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Freda Marshall December 12, 2005 11:02 /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3933 Layfield Road Salisbury Wicomico 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Month, Day Year 8/16/1943 9. Birthplace (State or Foreign Country) West Virginia **Funeral** Days Hours 1 □ M 2 K F 62 218-50-1479 Director Usual Residence of Decedent Pages 1 and 2 should be fited within 72 hours efter deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow the Medical Exempler must be notified at 1 ☐ Yes 2√2 No Director Maryland Wicomico Salisburv 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3933 Layfield Road 21804 "natural", or Items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: þ Specify: white 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'ally injury or other traumatic event, the Megicia. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grant Spencer Vivian Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cherry Moore/daughter 3933 Layfield Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory | 12-14-05 Salisbury, MD 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, ND 21804 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Dagen Immediate Cause (Final Physician annecs disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unseed of Vijer) that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transif attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 □ Yes 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 22 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy perfor 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes ≥ No 1 X atient 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Manper of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident investigation mpletely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) D26278 1.6. Boy 1733 Sality pos 21862 cause of death (Item 23a) Type, Print) Name and address of person who completed Couch MO Joshal Hospie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 5 2005 Registrar

|                            |  |                            | For<br>State<br>Registrar   | State of Ma   | ırylan      | •  | artmen<br>rtificate                              |                        |                                       | and M                  |  | Reg. No.       | 005                                     | 42362   |
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|                            | Physici<br>/Medio<br>Examir  | cal                        | 1. Decedent's Name (First, Middle, La  David Joshua  4a. Facility Name (If not institution, giv  Union Memorial   | McGlothl:   | in          |  |  | Town, or               | Location o                            |                        | 2. Date of De<br>Month<br>December   | Day 21 4c. Co. | Year 2005 unty of Deat City             |   |
| *                          | Funeral<br>Director  | 3032                       | 5. Social Security Number 6.3   |   | 81 (In yrs. | last birthday)<br>Yrs.                   | If Under<br>Months                               |                        | If Under<br>Hours                     | 24 Hrs.<br>Min.        | 8. Date of Birt<br>1 1/13/   |                | 9. Birt<br>Co                           | hplace (State or Foreign<br>untry)<br>ginia     |
|                            | e Maryland<br>sa-f ehow  | ctor                       | 10a. State 10b. County MD Baltin  | ore   | 10c. Cit    | y, Town or Lo<br>Balti                   |  |                        |                                       |                        |  |                |   | 10d. Inside City Limits 1 ☐ Yes 2X No           |
|                            | ath with th  | Funeral Director           | 10e. Street and Number<br>6727 Mallard Ro   | pad   |             |  | 10f. Zip   | Code<br>1220           |                                       |                        |  |                | of What Co                              | •   |
| 036                        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: if item 27 is marked other then "natural", or itams 23a or 28a-f show important: if item 27 is marked other then "natural", or itams 23a or 28a-f show yillying or other treumatic event, its Medical Examinar must be collified at once.   | ۾                          | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced   | 12. Was Decedent If Armed Forces?  1 TYPES 2 Note: 1 Yes, Give Year or Dates: | lo          | '  | Was Deced<br>If Yes, spec<br>1 ☐ Yes 2           | rify Cuba              | spanic Orig<br>n, Mexican<br>Specify: | gin? (Spe<br>i, Puerto | ecify Yes or No<br>Rican, etc.)  |                | Race - Ame<br>Black, White<br>ecify: Wh | e, etc.   |
| Maryland 21215-0036        | d within 72 h<br>giene,<br>ir then "natu   | Completed                  | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0-12)   | ducation<br>ade completed)<br>College (1-4or 5                                | +)          | life.                                    | dent's Usua<br>kind of woi<br>DO NOT us<br>k dri | k done d<br>e retired, | urina most                            | t of worki             | ng   |                | of Business/<br>sporta:                 |   |
| yland                      | should be filed vind Mental Hygie marked other tumatic event, ID   | To Be C                    | 17. Father's Name (First, Middle, Las.<br>Walter McGloth  |   |             |  |  |                        |                                       |                        | (First, Middle,<br>Ferren  | Maiden Sui     | тате)                                   |   |
| , Man                      | 1 and 2 sho<br>Health and<br>Ism 27 is mu  |                            | 19a. Informant's Name/Relationship Shelby Dahl  | (Type, Print)<br>(Sister)   |             | 6727                                     | Mall   | ard                    |                                       | Ba]                    | Route Number   |                | 21220                                   | (ip Code)                                       |
| Baltimore,                 | Pages 1<br>ment of H<br>lant: if its   |                            | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Special Content of the Content |   | 0           | Place of Dispo<br>emetery, crer<br>A. Fe | natory or o                                      | ther place             |                                       | 2/23                   | 3/05   |                | cheste                                  | Town, State<br>er, PA                           |
| Balt                       | permit. Page<br>Department of<br>Important: if<br>eny injury or<br>once.   |                            | 21. Signature of Funeral Service Lice   | y My  | est         | 14                                       | Aberd  | een,                   | MD                                    | 2100                   | eral Hor<br>11-3399  |                | Α.                                      |   |
|                            | Physician<br>/Medical  |                            | Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  | a. Substitutions that caused one cause on each line a. Due to (or as          | 18.         |  | er the mode                                      | e of dying             | g, such as                            | cardiac c              | or respiratory ai  | rrest,         |   | Approximate Interval Between Onset and Death    |
| 8760, <                    | sate be executed by yesician and the burial-transit  | Physiclan/Medical Examiner | Sequentially list conditions, if any, leading to intribution cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  | b. C. Alff. Cue to (or as Due to (or as d.                                    | Coliti      | uence of).                               |  |                        |                                       |                        |  |                |   |   |
| P.O. Box 6                 | The law requires that the death certificate be executed tie hes been signed by the attending physician and oase 2 should be detached for use as the burial-transit   | ysiclan/Med                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1□Live birth<br>4□Pregnant at<br>9□Unknown            | 2 Feta      | ldeath 3□                                | Ectopic pr                                       |                        |                                       |                        |  | 23d.           | . Date of deli<br>Month                 | very<br>Day Year                                |
|                            | iw requires that<br>s been signed b<br>should be deta  | þ                          | Part II. Other significant conditions   | contributing to death bi  | ut not res  | ulting in the u                          | nderlying ca                                     | ause give              | n in Part I.                          |                        | 23e. Did to  | _/             |   | the cause of death?                             |
| Division of Vital Records, | : The law re<br>cate hes be<br>page 2 sho  | Completed                  |   |   |             |  |  |                        |                                       |                        |  |                | 4b. Were au prior to death?             | topsy findings available completion of cause of |
| <u> </u>                   | sician: Th<br>certificate<br>irector, pag  | o Be                       | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:   | 20          | ER/Outpatier                             |  | Othe                   | r                                     |                        | Check only o   |                | 10                                      |   |
| ion of                     | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page  | H                          | 27. Manper of Death  1. Natural 5 Pending 2 Accident investigation  |   | v           | 28b. Time of Injury                      |  | Bc. Injury<br>Work     | 4 LI NU                               |                        | me 5 Residence R |                |   | cify)   |
| N<br>N                     | ospitai or Attend<br>hours after death<br>uneral Director:<br>ly filled in by the  | Certification:             | 3 Suicide 6 Could not l   | building, etc   | : (Specif   | y)                                       |  |                        |                                       |                        | City or Tov  | vn, State)     |   | ral Route Number,                               |
|                            | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in  | Medical                    | one)  | hysician: To the best of miner: On the basis of and manner sta                | examina     | tion and/or in                           | vestigation,                                     | in my op               | inion, dea                            | th occurr              | ed at the time,  | date and pla   | ice, and due                            | to the cause(s)                                 |
|                            | Month of the contract of the c | 2                          | 29b. Signature and title of certifier   | Ted   | MD          |  | 290  | License<br>U.41        | 764                                   | 351                    |  | -              |   | 21, 2005  |
|                            | 641  |                            | 30. Name and address of person who  | completed cause of d  | eath (Item  | n 23a) (Туре,<br>Момо                    | Print)   | Hosp                   | stal                                  | , M                    | D  |                | ***                                     |   |
|                            | Sta<br>Regist  |                            | 31. Date filed (Month, Day, Year) DEC 3 0 2   | 005 Aegistra  | ar's Signa  | A PAGE                                   | W.   | ,                      |                                       |                        |  |                |   |   |

|            |   |                | For State  | te of Maryland   |                                  | rtment of He                                   |   | -                                       | _                                       | 10000   |
|------------|---|----------------|--|--|----------------------------------|--|---|---|---|---|
|            |   |                | For State Registrar  |  | Cer                              | tificate of E                                  | Death   |   | CUU-Jan                                 | 42363   |
| 2          | Physicia  | an             | 1. Decedent's Name (First, Middle, Last)  Herbert Wyatt  | Marti  | iA                               | lv.  |   | 2. Date of Death Month                  | Day 20 Aco                              | 3. Time of Death 5 0936 AM                          |
|            | /Medic  | al             | 4a. Facility Name (If not institution, give street a   |  |                                  | 4b. City, Town, or 1                           | Location of Death                             | Duerred                                 | 4c. County of Dea                       |   |
|            | Examin  | er             | Washington County Ho   |  |                                  | Hagers   |   | ·                                       | Washing                                 |   |
| 5          | Funeral   |                | 5. Social Security Number 6. Sex 186–28–7229 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                   | 7. Age (In yrs. la   | ast birthday)<br>O Yrs.          | If Under 1 Year<br>Months Days                 | If Under 24 Hrs.<br>Hours Min.                | 8. Date of Birth<br>(Month, Day, Yo     | 9. Bi                                   | rthplace (State or Foreign ountry)                  |
|            | Director  |                | Usual Residence of Decedent  |  |                                  |  |   | Nov 24, 1                               |   | PA  |
|            | within 72 hours after death with the Maryland<br>ene.<br>Than "natural", or items 23a or 28a-f show<br>Ta Mardical Exercities cust be chilling at                                     | Z.             | PA Franklin  | 10c. City  | r, Town or Loc                   | esboro   |   |   |   | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No              |
|            | the M   | Director       | 10e. Street and Number   |  | Wayii                            | 10f. Zip Code                                  |   | 10g                                     | . Citizen of What C                     |   |
| ,          | h with  |                | 11922 Country C  | 1ub Road   |                                  |  | 17268   |   | USA                                     |   |
|            | death   | Funeral        | 11 Marital Status 12. Wa   | s Decedent Ever in U.S<br>led Forces?                          | S. 13. V                         | Vas Decedent of His<br>Yes, specify Cubar      | spanic Origin? (Spe<br>n. Mexican, Puerto F   | cify Yes or No-<br>Rican, etc.)         | 14. Race - Am<br>Black, Whi             |   |
| 36         | or It   | by Fu          | 1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | Yes 2 No   |                                  | □Yes 2√2 No                                    | Specify:                                      |   | Specify: W                              |   |
| 21215-0036 | hour<br>tural'  | ed p           | 3 ☐ Widowed 4 ☐ Divorced Yes   | ir or Dates: 1955-   |                                  | ent's Usual Occupa                             | tion  | 16                                      | b. Kind of Business                     |   |
| 215        | nin 72<br>In "na<br>Macilia   | piet           | (Specify only highest grade comp   | lege (1-4or 5+)  | (Give                            | kind of work done di<br>OO NOT use retired)    | uring most of workir                          | ng                                      |   | ,   |
| 21         | be filed within 72 ho<br>traf Hygiene.<br>Ind other than "natu<br>avent, the Mardical   | Completed      |  | 1  | So                               | 1dier  |   |   |   | vernment  |
| Maryland   | should be filed within<br>nd Mental Hygiene.<br>marked other than<br>imatic avent, the M  | Be             | 17. Father's Name (First, Middle, Last)  | + : - O  |                                  |  | 18. Mother's Name                             |   | iden Sumame)                            |   |
| 7          | 2 should be f<br>and Mental H<br>le marked of<br>raumatic ave   | မ              | Herbert Wyatt Mar  |  | 19b. Mailin                      | g Address (Street a                            | The 1 ma                                      |   | city or Town. State.                    | Zip Code)   |
| <b>≥</b>   | 2 6 9 8   |                |  | wife   |                                  | 22 Countr                                      |   |   |   |   |
| re,        | ss 1 and 3<br>of Health<br>item 27<br>other tr  |                | 20a. Method of Disposition   | 20b. P   | lace of Dispos                   | sition (Name of natory or other place          | D   |   | c. Location - City o                    |   |
| ii.        | nit. Pages<br>artment of h<br>ortant: If ite<br>injury or of  |                | 1   Burial 2 □ Cremation 3 □ Remova  □ □ Conation 5 □ Other (Specify)  |  | oaugh (                          | Church Cer                                     | p. Dec 2                                      | 3 ZUUD F.                               | ashingtor<br>ranklin (                  | 'O PA   |
| Baltimore, | permit. Pag<br>Department<br>Important: I<br>any injury o   |                | 21. Signature of Funeral Service Licensee  | 11 1.00  | 22                               | . Name and Address                             | s of Facility Grov                            | ve-Bowers                               | sox Funer                               | al Home, Inc.                                       |
| 94         | 40 E # 0  |                | 232 Part Edge the disease or complications   |  | Do not ente                      | O S. Broa                                      | nd St. Way                                    | nesboro,                                | PA 1726                                 | Approximate Approximate                             |
| 1          |   |                | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus immediate Cause (Final | e on each line.  | 0= 110                           | 1 15 170                                       | 00 0  | zaitie                                  | •                                       | Interval Between<br>Onset and Death                 |
| lar.       | Physician<br>/Medical   |                |  | ue to (or as a consequ   |                                  | ( 00/10  | ( perio                                       | G11115                                  |   |   |
|            | Examiner  |                | Samuelially list a militime  | Bensis   |                                  |  |   |   |   |   |
|            | P = 3   | iner           | cauca Enter Underlying   | ue to (or as a consequ   |                                  | 110  |   |   |   |   |
| ٧          | and<br>and<br>Il-trans  | Examiner       | that initiated events resulting in death) Last   | es or as a consequ   |                                  | Filma  |   |   |   |   |
| 760        | ate be executed<br>nysicien and<br>he burial-transit  | caiE           | 4  |  |                                  |  |   |   |   |   |
| 68         | tificate<br>ig phy<br>as the  |                |  | 7.77   |                                  |  |   |   |   |   |
| Box        | eath certificat<br>attending phy<br>I for use as the  | an/N           | 23b. was decedent pregnant   | es, outcome of pregna<br>Live birth 2 Petal                    |                                  | Ectopic pregnancy                              |   |   | 23d. Date of de                         | elivery<br>Day Year                                 |
| .O. E      | the at  | Physician/Med  |  | Pregnant at time of de<br>Unknown                              | eath 5□                          | Other (specify)                                |   |   | Worten                                  | Day 19ai  |
| <u>α</u>   | es that the de<br>igned by the a<br>be detached f   |                | Part II. Other significant conditions contributing   | g to death but not resu  | ulting in the ur                 | nderlying cause give                           | n in Part I.                                  | 23e. Did tobac                          | cco use contribute                      | to the cause of death?                              |
| rds        | quires<br>in sign<br>uld be   | ed by          | METESTATIC BIG   | dde C  | 000                              | v  |   | 1 ☐ Yes                                 | 2 No 3 P                                | robably 4 Umknown                                   |
| Records,   | The law requires that the death certifica<br>ste has been signed by the attending ph<br>age 2 should be detached for use as th  | Completed      | Hypertersion   |  |                                  |  |   | 24a. Was an autopsy                     | 24b. Were a                             | utopsy findings available<br>completion of cause of |
| Ä          | The<br>cate his<br>page   | Com            | active revel f   | zilwe  |                                  |  |   | performe<br>1 ☐ Yes 2 ☑                 | d? death?                               | s 2□No  |
| Vital      | Physician:<br>r this certifica<br>ral director, i   | Be             | 25. Was case referred to medical examiner?   |  |                                  | Othe   | 26. Place of Death                            | 100                                     |   |   |
| of         | Phys<br>r this<br>rat dir   | 5. T           | To res 212 100   | Date of Injury   | ER/Outpatien<br>28b. Time of     | t 3□ DOA Othe                                  | 4 🗀 Nursing Hor                               | ne 5 Residence<br>8d. Describe how      | injury occurred                         | ecify)  |
| on         | Attending in death. ector: After by the fune  | ation          | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day Year)  | Injury                           | Work   | ?<br>'es 2 □ No                               |   | , ,                                     |   |
| Division   | r Attendi<br>er death.<br>rector: A<br>by the fu  | Certification; | a Could not be   | Place of Injury - At ho<br>building, etc. (Specify             | ome, farm, str                   | eet, factory, office                           | 2   | 28f. Location (Stree<br>City or Town, S |   | Rural Route Number,                                 |
|            | oltal or<br>urs aft<br>ral Di<br>lled in  | Cer            |  |  |                                  |  |   |   |   |   |
|            | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical        | 29a. Certifier 1 [▼Certifying Physician:  (Check only one) 2 Medical Examiner: Or one)                             | To the best of my known the basis of examinal dimanner stated. | wiedge, death<br>tion and/or inv | n occurred at the tim<br>restigation, in my op | e, date and place, a<br>pinion, death occurre | and due to the caused at the time, date | se(s) and manner a<br>and place, and du | is stated.<br>le to the cause(s)                    |
|            | To the comp   | M              | 29b. Signature and title of certifier  | 000  | \                                | 29c. License                                   |   | 29d                                     | . Date signed (Mor                      | ith, Day, Year)                                     |
|            | 04  |                | France O De  |  | )                                |  | 06117   | 10                                      | 19110                                   | )   |
|            | 12  |                | 30. Name and address of person who complete  | d cause of death (Item   | 23a) (Type,                      | Print)   | Autretu                                       | ~ 5T.                                   | 1 ager a                                | zur MD  |
| 50         | Sta   | ate            | 31. Date filed (Month, Day, Year)  | 32. Pagistrar's Signa  | ture                             | 251 E.   | 1,70,71,00                                    | ,                                       | J +3!                                   | 71-   |
| -          | Regist  |                | DEC 3 0 2005   | Masure .   | B B                              | CARRIED .                                      |   |   |   |   |

| Physician |
|-----------|
| /Medical  |
| Examiner  |
|           |

Itam 27 le marked other than "naturel", or itama 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 2 should be filed within 72 hours after I and Mental Hygiene.

Is marked other than "nature!", or Ital.

**Physician** /Medical Examiner

burial-transit The law requires that the death certificate be executed physician and Records, P.O. Box 68760 the as attending p certificate Division of Vital o the Hospital or Attending Physician: (his After this death. Director: / after

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 10, 2005 1:42AM december Joseph F.X. Mayhew 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Lanham Doctors Community Hospital 7. Age (In yrs. last birthday)
92 Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. May 7, 1913 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1⊠M 2□F 577-03-7255 Director Washington, DC Usual Residence of Decedent 10b County 10c. City. Town or Location 10a State 10d. Inside City Limits Prince George's Bowie Maryland 1 XYes 2 No Director 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 20715 USA 13208 Yorktown Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2 ☑ No Specify: White Specify ģ 3 N Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Dept. of Navy 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 le marked oth any injury or other traumatic event once. Nora McLean Joseph A. Mayhew ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph C. Mayhew 1987 Latarche Ave. North Port, Florida 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 12-14-05 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy Bowie, MD 4011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) espiratory Due to (or as a consequence of) 12109(3) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed o card 24b. Were autopsy findings available prior to completion of cause of death?

1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \) 24a. Was an autopsy performed? Yes 2 A No Heart 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 [7] Noatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD60411 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASPAW, MD 8118 Good Luck Road Landam MD 20709 31. Date filed (Month, Day, Year)
DEC 1 2 20

DHMH 17 Rev 1/2001

State Registrar

|                   |   |                               | For<br>State<br>Registrar   |                              | State of   | Marylan                                      | -                              | artmen<br><i>rtificat</i>   |                          |                           |                             |   | giene<br>Reg. No.          | 005                               | 42365  |
|-------------------|---|-------------------------------|---|------------------------------|--|--|--------------------------------|-----------------------------|--------------------------|---------------------------|-----------------------------|---|----------------------------|-----------------------------------|--|
|                   | Physici   |                               | 1. Decedent's Name (Firs  | t, Middle, La                | ast)   |  |                                |                             |                          |                           | 2                           | Date of Dea                             | ath<br>Day                 | Year                              | 3. Time of Death                                   |
|                   | Physici<br>/Medio   |                               | Dianne  |                              | Murphy   |  |                                | ,                           |                          |                           | No                          | ov.                                     | 30                         | 2005                              | 10:50 a™   |
|                   | Examir  |                               | 4a. Facility Name (If not in  | nstitution, gi               | ve street and num                                    | ber)   |                                | 4b. City,                   | Town, or                 | Location of               | of Oeath                    |   | 4c. C                      | ounty of Death                    |  |
|                   |   |                               | Laurel Reg  |                              |  |  |                                |                             | urel                     |                           |                             |   |                            | nce Geo                           |  |
|                   | Funeral<br>Director   |                               | 5. Social Security Number 218-73-2567   |                              | Sex 7<br>1 □ M 2 1 T F                               | Age (In yrs.                                 |                                | If Under<br>Months          |                          | If Under<br>Hours         | Min. No                     | Oate of Birt<br>(Month, Da)<br>OV • 8 • | h<br>y, Year)<br>1959      | 9. Birth<br>Cou<br>Jama           | place (State or Foreign<br>ntry)<br>BICA           |
|                   | and and   | }                             | Usual Residence of Dece<br>10a. State 10b.  | County                       |  | 10c. Cit                                     | y, Town or Lo                  | ocation                     |                          |                           |                             |   |                            |                                   | 10d. Inside City Limits                            |
|                   | darylan<br>f show   | ō                             | MD Pr   | ince (                       | Georges  |  | Laure                          | . 1                         |                          |                           |                             |   |                            |                                   | 1X∑Yes 2 ☐ No                                      |
|                   | 1he 286   | rec                           | 10e. Street and Number  | THEE V                       | Jeorges  |  | паите                          | 10f. Zip                    | Code                     |                           |                             |   | 10g. Citize                | n of What Cou                     | ntry?  |
|                   | 3e ou   | <u>a</u>                      | 14011 B. Ju   | etin I                       | Jav  |  |                                |                             | 20705                    |                           |                             |   | 11                         | SA                                | ŕ  |
|                   | ms 2  | Jera                          | 11. Marital Status  | Stan 1                       | 12. Was Deced  | lent Ever in U                               | S. 13.                         |                             |                          |                           | igin? (Specif               | y Yes or No-<br>an, etc.)               |                            | Race - Ameri                      |  |
| 21215-0036        | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "naturel", or Items 23e or 28e-f show other traumatic event, Ite Marical Executes it is at the notified at   | Completed by Funeral Director | 1 X Never Married 2<br>3 ☐ Widowed 4 ☐ [  |                              | Armed Ford<br>1 Yes 2<br>If Yes, Give<br>Year or Dat | No No  |                                | if Yes, spe<br>1 ☐ Yes      |                          | n, Mexicar<br>Specify:    |                             | an, etc.)                               | i                          | Black, White,  pecify:  B.        | etc.<br>Lack                                       |
| Ŏ                 | 2 ho  | ted                           |   | ecedent's E                  |  |  | 16a. Dece                      | dent's Usu                  | al Occupa                | ation                     |                             |   | 16b. Kind                  | of Business/Ir                    | dustry   |
| 2                 | within 7<br>ene.<br>then "n   | pie                           | Elementary/Secondary  | <del> </del>                 | rade completed) College (1-                          | 4or 5+)                                      | life.                          | DO NOT u                    | se retired               | iuring mos<br>)           | t of working                |   |                            |                                   |  |
| 21                | gien<br>grith   | Con                           | 12th  |                              |  |  | Tou                            | ır Tra                      | ansla                    | ator                      |                             |   | Tou                        | r Wise                            |  |
| pu                | be filed<br>tal Hygid<br>d other<br>event, II   | Be (                          | 17. Father's Name (First,   | Middle, Las                  | t)   |  |                                |                             |                          | 18. Mothe                 | er's Name (F                | First, Middle,                          | Maiden Si                  | umame)                            |  |
| Maryland          | should to<br>nd Ment<br>marked<br>umatic e  | 2                             | linton Geor   | ge Mu                        | rphy   |  |                                |                             |                          | Haz                       | el Wil                      | liams                                   |                            |                                   |  |
| ar                | 2 sho<br>and<br>is my   |                               | 19a. Informant's Name/F   | elationship                  | (Type, Print)  |  | 19b. Maili                     | ng Address                  | (Street a                | and Numbe                 | er or Rural R               | lou <i>te Numbe</i>                     | er, City or T              | own, State, Zij                   | o Code)  |
|                   | Health and tem 27 is rother treur   |                               | Ruth Murphy   |                              | er   | 1  |                                | . В Јі                      |                          |                           |                             | cel, M                                  |                            | 705                               |  |
| ore               | of H<br>of H<br>of H<br>if iten   |                               | 20a. Method of Disposition 1 XBurial 2 ☐ Cre  |                              | □Removal from S                                      | ate 20b. P                                   | lace of Dispo<br>emetery, crea | osition (Nar<br>matory or c | me of<br>other plac      | θ)                        | Date                        | Э                                       | 20c. Loca                  | ition - City or T                 | own, State   |
| Ē                 | Pages<br>ment of<br>ent: If it<br>ury or o  |                               | `4 ☐ Donation 5 ☐   |                              |  |  | er Tow                         |                             |                          |                           | 12-13-                      |   |                            | t Ann,                            | Jamaica  |
| Baltimore,        | permit. Pages 1 and Department of Healinportent: If item 2 any injury or other once.  |                               | 21. Signature of Funeral  | Service Lice                 | us Shall   |  | N<br>N                         | Name ar<br>Marsha<br>1217   | all s                    | s of Facilit<br>Fundation | eral F                      | lome,<br>Vashin                         | Inc.                       | DC 200                            | 011  |
|                   | Physician<br>/Medical   |                               | 23a. Pa Enter the dis<br>sh. k, or heart failu<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)     | ease, or con<br>re. List ont | a. Peri  | used the deatich line.  cardia r as a conseq | 1 Effu                         |                             | de of dying              | g, such as                | cardiac or re               | espiratory ar                           | rest,                      |                                   | Approximate<br>Interval Between<br>Onset and Death |
| 8760,             | certificate be executed by the certificate be executed by the certificate as the burial-transit but the certificate as the burial-transit but the certificate but the | Physician/Medical Examiner    | Sequentially list condition cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | ns,                          | c  | r as a conseq                                |                                |                             |                          |                           |                             |   |                            |                                   |  |
| .O. Box 6         | death certific<br>e attending p<br>ed for use as  | nysician/Mec                  | IF FEMALE: 23b. Was decedent preg in the past 12 montl 1 □ Yes 2 ☒ No 9 □ Unknown   |                              |  | th 2 ☐ Feta<br>nt at time of d               | Ideath 3                       | □Ectopic pi<br>□ Other (sp  |                          |                           |                             |   | 230                        | d. Date of deliver                | ery<br>Day Year                                    |
| Records, P.       | equires that the de<br>sen signed by the a<br>ould be detached t  | Completed by P                | Part II. Other significant General De   |                              |  | ith but not res                              | ulting in the u                | nderlying o                 | ause give                | en in Part I.             |                             |   | obacco use<br>′es 2 🔀 I    |                                   | he cause of death?                                 |
| CO                | S b   | ojete                         | Pleural Eff   | usion                        |  |  |                                |                             |                          |                           |                             | 24a. Was                                |                            | 24b. Were auto                    | opsy findings available                            |
| Be                | 0 = 0   | E O                           | Channin II.d  | abe Ta                       |  |  |                                |                             |                          |                           |                             | autop                                   | rmed?                      | death?                            | mpletion of cause of<br>2□ No                      |
| tal               | icien: Th<br>certificate<br>rector, pag   | BeC                           | Chronic Wei 25. Was case referred to  |                              | oss  |  |                                |                             |                          | 26 Place                  | of Death (                  | 1 ☐ Yes<br>Check only or                |                            | 1 🗆 Yes                           | 2   140  |
| >                 | Physicien:<br>this certific<br>ral director,  | ToB                           | examiner?<br>1 ☐ Yes 2 🛣 No   |                              | Hospital:  | patient 2                                    | ER/Outpatier                   | nt 3 🗆 DC                   | Othe                     |                           |                             |   |                            | ☐Other (Specif                    | ₹v)  |
| Division of Vital | Attending Phys<br>r death.<br>sctor: After this<br>by the funeral di  | ation: T                      | 27. Manner of Death 1 XNatural 5 C  | Pending<br>investigation     | 28a. Date of<br>(Month                               |  | 28b. Time o<br>Injury          |                             | 28c. Injury<br>Work      |                           | 280                         | I. Describe h                           |                            |                                   | ,,   |
| Divis             | el or Atte<br>s after de<br>al Directo  | Certification:                | 3 Suicide 6 C<br>4 Homicide   | Could not l<br>determined    | 28e. Place   | f Injury - At ho<br>g, etc. (Specif          | ome, farm, str                 | reet, factory               | y, office                |                           | 28f                         | Location (S<br>City or Tow              |                            | Number or Aura                    | al Route Number,                                   |
|                   | To the Hospitel or Attending I with n 24 hours after death. To the Funerel Director: After completely filled in by the funer  | Medical                       | 29a. Certifier 1 X (Check only one)   | Certifying P<br>Medical Exa  | hysician: To the bas<br>and manne                    | is of examina                                | wladge, deat<br>tion and/or in | h occurred<br>vestigation   | at the tim<br>, in my op | e, date an<br>pinion, dea | d place, and<br>th occurred | I due to the c<br>at the time, c        | cause(s) ar<br>date and pl | nd manner as s<br>ace, and due to | tated.<br>o the cause(s)                           |
|                   | with n<br>To th<br>comp   | M                             | 29b. Signature and title of   | certifier _                  |  |  |                                | 290                         | c. License               | number                    |                             | 2                                       | 29d. Date s                | signed (Month,                    | Day, Year)   |
| •                 |   |                               | <b>)</b>  | N                            | Mi.  | MI   |                                | T                           | 04521                    | 7                         |                             |   | 12                         | /1/2005                           |  |
| 6                 | (n)   |                               | 30. Name and address of   | person who                   | completed cause                                      | of death (Item                               | 23a) (Type.                    |                             |                          | •                         |                             |   |                            | , ~, ~003                         |  |
| -                 | (0)   |                               | A. Ajayi, M   | -/                           | ) Green  | 1 1 1 1 1 1                                  | 1000000                        |                             | olleg                    | ge Pat                    | IK, ML                      | 20740                                   | 0                          |                                   |  |
|                   | Sta<br>Registi  |                               | 31. Date filed (Month. Da   |                              | o <b>d</b> n.  | gistrar's Signa                              | A                              |                             |                          |                           |                             |   |                            |                                   |  |

| The Content      |          |  |       | State of Maryland / Dep  |   | Mental Hygi        | ene<br>2005               | 42366                 |
|--|----------|--|-------|--|---|--------------------|---------------------------|-----------------------|
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| State State   Security Number  |          |  |       |  |   |                    |                           |                       |
| St. Thomas Nore    St. Thomas Nore   S. Det Book   Thomas   S. Det   S. App (Prix National)   Fluid   T. App (Prix National)   Fluid |          |  |       |  | 4b. City, Town, or Location of Death  |                    |                           | 7.55 1                |
| Social Service y Numbers   Service   |          | LX   |       | St. Thomas More  | 1   |                    | Prince Geo                | rges                  |
| Type      |          | Funeral  |       | Social Security Number     Sex     7. Age (In yrs. last birthday)                    | If Under 1 Year If Under 24 Hrs.  | 8. Date of Birth   | 9 Birthol                 | ace (State or Foreign |
| Time State   Time County   Time State   Time County   Time State   Time County   Time State      |          |  |       | 579-01-3016  | Morais Days Hours Will.   | June 15            | , 1916 Sout               | h Carolina            |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, |          | pu ,   |       |  | acation.  |                    |                           | od Leede Obertiebe    |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, |          | aryla<br>shov                                    | -     |  |   |                    | "                         |                       |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, |          | Ne M   | ecto  |  |   | 10                 | - 0101                    |                       |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, |          | with t   | ä     |  |   | 10                 |                           | try r                 |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, |          | s 23   | erai  |  |   | pecify Yes or No-  |                           | an Indian             |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, |          | ter d  | F     | 1 Never Married 2 Married 1 Tyes 2 No 1  | If Yes, specify Cuban, Mexican, Puerto  | Rican, etc.)       |                           |                       |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, | 3        | urs a  | by    | If Yes, Give   | 1 ☐ Yes 2 X No Specify:   |                    | Specify: B1               | ack                   |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, |          | 72 ho  | ted   | 15. Decedent's Education 16a. Dec  | edent's Usual Occupation  | rina 10            | 6b. Kind of Business/Ind  | ustry                 |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, | -        | thin 7   | npie  | Elementary/Secondary (0-12) College (1-4or 5+)                                       | DO NOT use retired)   | urig               |                           |                       |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, | 7        | ed wi  | Son   |  |   |                    |                           | Stores                |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, | 2        | be filk<br>ta! Hy<br>d oth<br>event              |       |  |   | •                  | aiden Sumame)             |                       |
| Forrest McIlwain/Nephew    Forrest McIlwain/Nephew   100 Rowland Dr. Port Deposit, Md. 21904   200 Location. Cay of Town, State   200 Location. Cay of Town, | 2        | Men<br>Merke<br>parke                            | ပ္    |  |   |                    |                           |                       |
| 23a. Pfpf. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as sardact or disspiratory arrest.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate and Death Inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one causer on each inc.  Approximate Causer failure. List only one causer on each inc.  In Causer fai | <u> </u> | 12 sh<br>h and<br>7 is m<br>rraum                |       |  |   |                    |                           | Code)                 |
| 23a. Pfpf. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as sardact or disspiratory arrest.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate and Death Inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one causer on each inc.  Approximate Causer failure. List only one causer on each inc.  In Causer fai | ב<br>ט   | 1 and<br>Health<br>em 23<br>ther 1               |       |  |   |                    |                           | wn State              |
| 23a. Pfpf. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as sardact or disspiratory arrest.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate and Death Inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one causer on each inc.  Approximate Causer failure. List only one causer on each inc.  In Causer fai | 5        | ages<br>nt of l<br>: If it                       |       | Tabunar 2 Cremation 3 Linemoval from State   | ,   | _                  |                           | , Oldio               |
| 23a. Pfpf. Enter the disease. or complications that caused the death. Do not enter the mode of dying, such as sardact or disspiratory arrest.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one cause on each inc.  Approximate and Death Inc.  Approximate Causer failure. List only one cause on each inc.  Approximate Causer failure. List only one causer on each inc.  Approximate Causer failure. List only one causer on each inc.  In Causer fai |          | it. P.   |       |  |   |                    |                           |                       |
| Physician (Modical Examiner  Physician (Modical Examiner)  Physici | Ö        | Dep<br>any<br>any                                |       | V. P. Marshall   | Marshall's Funeral  | Home, In           | ic.                       |                       |
| Physician //Medical Examiner  Examiner  Examiner  Description of the condition of death of the condition of  |          | EX.  | -     | 23a, Page. Enter the disease, or complications that caused the death. Do not e       |   |                    |                           | Approximate           |
| Due to (or as a consequence of):   |          | Physician  |       | Immediate Cause (Final   | DI THEADO   | TIAN               |                           | Onset and Death       |
| Due to (or as a consequence of): d.    Due to (or as a consequence of):  |          | /Medical   |       | resulting in death)  | 1011/20   | 17077              |                           | 5MIJ.                 |
| Due to (or as a consequence of):    Due to (or as a consequence of):   |          | Examiner   |       | Superfield for conflict  | Mellitus  |                    | > 4                       | ead                   |
| Due to (or as a consequence of):    Due to (or as a consequence of):   |          | p =  | iner  | if any, leading to immediate cause. Enter Underlying                                 |   |                    |                           |                       |
| The part of the pa |          | ecute<br>and<br>trans                            | cam   | Cause (Disease or injury that initiated events c.                                    |   |                    |                           |                       |
| State   Control of the control of    | Š        | be ex<br>cian<br>ourial                          | Ë     | Due to (or as a consequence of).   |   |                    |                           |                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution of contri | -        | b ys   |       | d  |   | ,                  |                           |                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution of contri | <        | certif<br>iding<br>ise as                        | √Me   |  |   |                    | 23d Date of delive        | nv                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution to the cause of death?    Part II. Other significant conditions contribution of contri | ב        | atter<br>for u                                   | ciar  | in the past 12 months?   |   |                    |                           | •                     |
| 25. Was case referred to medical examiner?  10 yes 2 No  26. Place of Death **Check only one)  27. Manner of Death  10 yes 2 No  28. Date of Injury  28. Place of Injury  28. Date of Injury  29. Date of Injury  29. Date of  | į        | the cachec                                       | hysi  |  |   |                    |                           |                       |
| 25. Was case referred to medical examiner?  10 yes 2 No  26. Place of Death **Check only one)  27. Manner of Death  10 yes 2 No  28. Date of Injury  28. Place of Injury  28. Date of Injury  29. Date of Injury  29. Date of  | ,        | s that<br>ned t                                  |       | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I.   | 23e. Did toba      | icco use contribute to th | e cause of death?     |
| 25. Was case referred to medical examiner?  10 yes 2 No  26. Place of Death **Check only one)  27. Manner of Death  10 yes 2 No  28. Date of Injury  28. Place of Injury  28. Date of Injury  29. Date of Injury  29. Date of  | ž        | quire<br>an sig                                  | edt   | Cormany ontery dise  | asl.  | 1 🗆 Yes            | 2 □ No 3 Proba            | ably 4 □Unknown       |
| 25. Was case referred to medical examiner?  10 yes 2 No  26. Place of Death **Check only one)  27. Manner of Death  10 yes 2 No  28. Date of Injury  28. Place of Injury  28. Date of Injury  29. Date of Injury  29. Date of  | )<br>)   | awre<br>is be                                    | piet  | Prograte Cancer  |   |                    |                           |                       |
| 27. Manner of Death 1 Solatural 2   Accident 3   Suicide 4   Homicide 28a. Date of Injury 4   Homicide 28b. Place of Injury 4   Homicide 28b. Place of Injury 4   Homicide 28c. Injury at Work? M 1   Yes 2   No 28c. Injury a | Ž        | The ate his page                                 |       | End stage Reval d  | isease.   | performe           | ed?   death?              |                       |
| 27. Manner of Death 1 Solatural 2   Accident 3   Suicide 4   Homicide 28a. Date of Injury 4   Homicide 28b. Place of Injury 4   Homicide 28b. Place of Injury 4   Homicide 28c. Injury at Work? M 1   Yes 2   No 28c. Injury a | <u> </u> | sien:<br>artifica                                | O     | eyaminer?  |   | ,                  |                           |                       |
| 28. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  20c. Registrar's Signature—  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3503  31. Date filled (Month, Day, Year)  22. Registrar's Signature—  228f. Location (Street and Number or Rural Route Number, City or Town, State)  287 Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3503  31. Date filled (Month, Day, Year)  22. Registrar's Signature—  23. Registrar's Signature—  24. Registrar's Signature—  25. Registrar's Signature—  26. Registrar's Signature—  27. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. | 5        | hysio  | .0    | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati                                  |   |                    |                           | )                     |
| 28. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  20c. Registrar's Signature—  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3503  31. Date filled (Month, Day, Year)  22. Registrar's Signature—  228f. Location (Street and Number or Rural Route Number, City or Town, State)  287 Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  3503  31. Date filled (Month, Day, Year)  22. Registrar's Signature—  23. Registrar's Signature—  24. Registrar's Signature—  25. Registrar's Signature—  26. Registrar's Signature—  27. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. Registrar's Signature—  28. | =        | ing P  | ion   | 1 Salatural 5 ☐ Pending (Month, Day Year) Injury                                     | Work?   | 28d. Describe how  | vinjury occurred          |                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN. R. TULI. WI)  3503 Persoy Street Mount Rainier. Mi) 20512  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature—  | 2        | death<br>ctor:<br>, the                          | icat  | 3 Suicide 6 Could not be an Place of Injury. At home farm                            |   | 28f Location (Stre | net and Number or Bural   | Route Number          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN. R. TULI. WI)  3503 Persoy Street Mount Rainier. Mi) 20512  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature—  | 2        | after<br>after<br>Direct                         | ertil | 4 Homicide determined building, etc. (Specify)                                       | sioot, taxiny, onto   |                    |                           |                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN. R. TULI. WI)  3503 Persoy Street Mount Rainier. Mi) 20512  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature—  |          | e Hospita<br>24 hours<br>e Funere<br>etely fille |       | (Check only 2 Medicel Examiner: On the basis of examination and/or                   |   |                    |                           |                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAMAN. R. TULI. WI)  3503 Persoy Street Mount Rainier. Mi) 20512  State  31. Date filed (Month, Day, Year)  22. Registrar's Signature—  |          | To th<br>within<br>To th<br>compl                | Me    | 29b. Signature and title of certifier  | 29c. License number   |                    | _                         | Day, Year)            |
| 3503 Perry Street Marnt Rainier. Mi) 20912  State 31. Date filed (Month, Day, Year) / 2. Registrar's Signature—  2. Registrar's Signature—  2. Registrar's Signature—  2. Registrar's Signature—  3. Date filed (Month, Day, Year) / 2. Registrar's Sign |          |  |       | * Kaluan K Culi.   | D19609.   | 12                 | 2.1.05                    |                       |
| 3503 Restry Street Mount Rainier. Mi) 20512.  State 31. Date filed (Month, Day, Year) 2. Registrar's Signature—  | /        | (3)  |       | 30. Name and address of person who completed cause of death (Item 23a) (Type         | Print) RAMAN.   | R. Tu              | LI. MI)                   |                       |
| DEC 19 2005  |          |  | 25    | 3503 Perry Street Mon.   | nt-Rainier. 1   | 11) 20             | 712                       |                       |
|  |          |  |       |  | de la companya della companya della |                    | - *                       |                       |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Theodore Roscoe Morgan December 2005 10:08 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Prince George's Ft. Washington Hospital Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 85 28, 225-10-3744 Sep. 1920 Virginia Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours efter death with the Maryland nant of Health end Mentel Hygiene.

Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Iry or other traumatic event, the Medical Examinar must be notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No Directo Oxon Hill Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5630 Helmont Drive 20745 United States Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify Black Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8th Grounds Keeper Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George R. Morgan Cassie N. West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 5630 Helmont Dr., Oxon Hill, MD Michael R. Morgan / Son 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of Important: If It any Injury or o 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 12/13/05 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 Llabor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) COronary a Examiner a consequence of) Physician/Medical Examinel Attending Physician: The law requires that the death certificate be executed use es the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician end Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? aftar death.

I Director: After this cartificate has been signed by it in by the funeral director, page 2 should be datac 4 Unknown 1 Yes 2 No 3 Probably Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? No No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours aftar To the Funeral Directomplately filled in by 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month. Dav. Year) DO05311 0 MD 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 11711 Livingston Rd., Ft. Wash., M.D. 20744 Patrick Day, M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State DEC 1 3 2005 Registrar

DHMH 16 Rev 6/95

|             |   |                  | 1 - For<br>State<br>Registrar   | State of Mary   |                                      | artment o                       |                      |                       | ınd M                |  | giene                      | 005                           | 423                                | 68     |
|-------------|---|------------------|---|---|--------------------------------------|---------------------------------|----------------------|-----------------------|----------------------|--|----------------------------|-------------------------------|------------------------------------|--------|
|             |   |                  | Decedent's Name (First, Middle, Last)   |   |                                      |                                 |                      |                       |                      | 2. Date of Dea<br>Month                    |                            | Vaca                          | 3. Time of De                      | ath    |
|             | Physici<br>/Medi  |                  | Pearlie H. McKed  | ogh   |                                      |                                 |                      |                       |                      | December                                   | c 10,                      | 2005                          | 4:12 P                             | М      |
| 7           | Examir  | ner              | 4a. Facility Name (If not institution, give sta   |   |                                      | 4b. City, To                    | wn, or L             | ocation of            | f Death              |  |                            | nty of Death                  |                                    |        |
|             |   |                  | 13205 Idlewild Driv   |   |                                      | BC<br>If Under 1                | wie                  | If Under 2            | ld Use               |  |                            |                               | orge's                             |        |
|             | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 1 1  | 4 0CYr  | yrs. last birthday)<br>37 Yrs.       |                                 | Days                 | Hours                 | Min,                 | 8. Date of Birth<br>(Month, Day<br>Jan. 30 | Year)<br>1018              | 9. Birth                      | place (State or Fi<br>ntry)<br>1 • | oreign |
|             |   |                  | Usual Residence of Decedent   |   | 57                                   |                                 |                      |                       |                      | Jan. Je                                    | 7,1510                     | PILII                         |                                    |        |
|             | ylanc<br>how  |                  | 10a. State 10b. County  | 100   | c. City, Town or Lo                  | cation                          |                      |                       |                      |  |                            |                               | 10d. Inside City L                 | imits  |
|             | the Marylar<br>28a-f show   | ctol             | MD Prince Geo   | rge's   | Bowie                                |                                 |                      |                       |                      |  |                            |                               | 1 XYes 2∣                          | □No    |
|             | ith th  | Dire             | 10e. Street and Number  |   |                                      | 10f. Zip Co                     | ode                  |                       |                      | 1  | l0g. Citizen o             | of What Cou                   | ntry?                              |        |
|             | death with the Maryland<br>ms 23e or 28a-f show   | Funeral Director | 13205 Idlewild Driv   |   |                                      |                                 | 0715                 |                       |                      |  | USZ                        |                               |                                    |        |
|             |   | nne              |   | . Was Decedent Ever<br>Armed Forces?  | in U.S. 13.                          | Was Deceden<br>If Yes, specify  | nt of Hisp<br>Cuban, | anic Orig<br>Mexican, | in? (Spe<br>Puerto   | cify Yes or No-<br>Rican, etc.)            | 14. R                      | ace - Ameri<br>lack, White,   |                                    |        |
| 36          | a o E   | by F             | 1 ☐ Never Married 2 ☐ Married 3 🏿 Widowed 4 ☐ Divorced  | 1 X Yes 2 □ No<br>If Yes, Give<br>Year or Dates: W/W                          | V II                                 | 1 ☐ Yes 2💢                      | ) No                 | Specify:              |                      |  | Spec                       | cify: Whi                     | te                                 |        |
| 21215-0036  | 72 hours after<br>neturel', or Ite  | ted              | 15. Decedent's Educa  | tion  | 16a. Dece                            | dent's Usual C                  | Occupation           | on                    |                      |  | 16b. Kind of               |                               |                                    |        |
| 215         | within 7.<br>ene.<br>than "n  | Completed        | (Specify only highest grade Elementary/Secondary (0-12)   | College (1-4or 5+)  | (Give                                | kind of work o<br>DO NOT use i  | done dur<br>retired) | ring most             | of worki             | ng   |                            |                               | ,                                  |        |
| 2           | ad wit  | Son              |   | 2   | Admi                                 | n. Ass                          | ista                 | ant                   |                      |  | Food 8                     | & Drug                        | Admin.                             |        |
| nd          | be file<br>tal Hy<br>d oth  | Be (             | 17. Father's Name (First, Middle, Last)   |   |                                      |                                 | 18                   |                       |                      | (First, Middle, i                          | Maiden Sum                 | ame)                          |                                    |        |
| yla         | Men<br>Men<br>Marke   | 2                | Willis Hargrave   |   |                                      |                                 |                      | Anna                  |                      |  |                            |                               |                                    |        |
| Maryland    | ges 1 and 2 should be filed within 72 hours<br>tt of Health and Mental Hygiene.<br>If item 27 Is marked other than "neturel",<br>or other treumetic event, If a Medical Exs |                  | 19a. Informant's Name/Relationship (Type  | •   |                                      |                                 |                      |                       |                      | l Route Number                             |                            |                               | Code)                              |        |
|             | of Health<br>of Health<br>litem 27  |                  | Mary Ann McKeogh / 20a. Method of Disposition   |   |                                      | Idlew                           |                      |                       |                      | Bowie,                                     | 20c. Location              | 20715                         | Ctata                              |        |
| Baltimore,  | Pages<br>nent of I<br>int: If it  |                  | 1 Burial 2 ☐ Cremation 3 ☐ Re   | noval nom State   | Ob. Place of Dispo<br>cemetery, crer |                                 |                      | - 1                   |                      |  |                            |                               | JWII, State                        |        |
| 턆           | permit. Pages<br>Department of<br>Importent: If i<br>any injury or once.  |                  | <ul><li>4 ☐ Donation 5 ☐ Other (Specify)</li><li>21. Signature of Funeral Service Licensee</li></ul>                              |   | Sacred He                            | eart Ce                         |                      | _                     |                      |  |                            |                               |                                    |        |
| Ba          | permit. I<br>Departm<br>Importer<br>any injur   |                  | Per   | You all   |                                      | 512 NW                          |                      |                       | Bea                  | all Fune                                   | eral Ho<br>e, MD.          | ome<br>2071                   | E                                  |        |
|             |   |                  | 23a. Part1. Enter the disease, or complica  | tions that caused the   |                                      |                                 |                      |                       | _                    |  |                            | 2071                          | Approximate                        |        |
|             | Physician   |                  | shock, or heart failure. List only one<br>Immediate Cause (Final  | cause on each line.   | -las                                 | 1                               | NL-                  | . /                   |                      |  |                            |                               | Interval Between<br>Onset and Dea  |        |
|             | /Medical  |                  | disease or condition resulting in death)  | Due to (or as a cor   | nsequence of);                       | La                              | 110                  |                       |                      |  |                            |                               | NONIE                              | 25     |
|             | Examiner  |                  | Convention line and divine  |   |                                      |                                 |                      |                       |                      |  |                            |                               |                                    |        |
|             | B #   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a cor   | nsequence of).                       | *                               |                      |                       |                      |  |                            |                               |                                    |        |
|             | scute<br>ind<br>trans   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last   |   |                                      |                                 |                      |                       |                      |  |                            |                               |                                    |        |
| 90,         | tate be executed oblysician and the burial-transit  | Ë                | resulting in death) cast  | Due to (or as a cor   | nsequence of):                       |                                 |                      |                       |                      |  |                            |                               |                                    |        |
| 8760,       | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit          | dicai            | d.  |   |                                      |                                 |                      |                       |                      |  |                            | -                             |                                    |        |
| 9 x         | leath certific<br>attending p   | Physician/Me     | IF FEMALE:  | . If yes, outcome of pr   | ragnanov.                            |                                 |                      |                       |                      |  |                            |                               |                                    |        |
| Box         | atten<br>for us   | ian              | in the past 12 months?  | 1 Live birth 2 ☐<br>4 Pregnant at time  | Fetal déath 3 □                      | Ectopic pregr<br>Other (special |                      |                       |                      |  |                            | Date of delive<br>Month       | ery<br>Day Year                    | 7      |
| P.O.        | the de<br>y the<br>iched  | ıysic            | 1 ☐ Yes 2 🖼 No<br>9 ☐ Unknown   | 9□ Unknown  | or death 3L                          | J Other (specii                 | ·y/                  |                       |                      |  |                            |                               |                                    |        |
|             | <ul> <li>requires that the deben signed by the should be detached</li> </ul>  | y PF             | Part II. Other significant conditions contr   | buting to death but no  | ot resulting in the u                | nderlying caus                  | se given             | in Part I.            |                      | 23e. Did tob                               | pacco use co               | ntribute to the               | ne cause of deat!                  | h?     |
| Records,    | quires<br>n sign  | ed by            |   |   |                                      |                                 |                      |                       | _                    | 1 □ Ye                                     | s 2 100                    | 3 🗌 Prot                      | ably 4 Unkr                        | nwor   |
| 000         | s bee   | Completed        |   |   |                                      |                                 |                      |                       |                      | 24a. Was a                                 |                            | . Were auto                   | psy findings avai                  | lable  |
| Re          | sicien: The law<br>certificate has b<br>irector, page 2 s   | mo               |   |   |                                      |                                 |                      |                       |                      | autops                                     | ned?                       | death?                        | inpletion of cause<br>2□ No        | ∍ of   |
| Vital       |   | a                | 25. Was case referred to medical  |   |                                      |                                 | 2                    | 6. Place o            | of Death             | 1 ☐ Yes 2                                  | e No                       | 10105                         | 2 140                              |        |
| f \         | > 0 0   | To B             | examiner? 1 \( \text{Yes}  2 \( \text{Vo} \)  | spital: 1 Inpatient   | 2 ER/Outpatien                       | t 3 DOA                         | Other                | 4 🗌 Nurs              | sing Hon             | ne 5 Neside                                | nce 6 □O                   | ther (Specif                  | y)                                 | ====   |
| 0 0         | ng Pł<br>fter tł<br>neral   |                  | 27. Manner of Death 1 ■ Natural 5 ■ Pending   | 28a. Date of Injury<br>(Month, Day Yea  | 28b. Time of Injury                  | 28c.                            | Injury at<br>Work?   | t                     | 2                    | 8d. Describe ho                            | w injury occu              | urred                         |                                    |        |
| Sio         | Attending It death. ector: After by the funer   | cati             | 2 Accident investigation 3 Suicide 6 Could not be   |   |                                      | М                               | 1 🗌 Yes              | s 2 🗆 N               | 0                    |  |                            |                               |                                    |        |
| Division of | l or At<br>after d<br>Direct  | Certification;   | 4 Homicide determined   | 28e. Place of Injury -<br>building, etc. (S <sub>I</sub>                      | At home, farm, stri<br>pecify)       | eet, factory, of                | ffice                |                       | 2                    | 8f. Location (St.<br>City or Town          | reet and Nun<br>, State)   | nber or Rura                  | l Route Number,                    |        |
|             | pitel   |                  | 29a. Certifier 1 Certifying Physic  | ion. To the best of my  | . Irmanula da a . da asti            |                                 | b = 4'               |                       | -1                   |  |                            |                               |                                    | - 1    |
|             | To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral   | Medical          | 29a. Certifier  (Check only one)  1 Certifying Physic  2 Medical Examine  | r: On the basis of examination of the basis of examination and manner stated. | mination and/or inv                  | estigation, in                  | ne time,<br>my opini | ion, death            | place, a<br>noccurre | nd due to the ca<br>ed at the time, da     | iuse(s) and nate and place | nanner as si<br>e, and due to | ated.<br>the cause(s)              |        |
|             | To the within 3   | Me               | 29b. Signature and title descrifier   |   |                                      | 29c. Li                         | icense n             | umber                 | _                    | 25   | 9d. Date sign              | ed (Month,                    | Day, Year)                         |        |
|             | ->-0  |                  | ) Steel m   |   |                                      | 1                               | 410                  | 97                    | X                    |  | 12-                        |                               | 2001                               | 5      |
| )           | III (0i)  |                  | 30. Name and address of person who com  | pleted cause of death   | (Item 23a) (Type.                    | Print)                          | 11,                  | / (                   | )                    |  | 16                         | 14                            |                                    | _      |
|             | U Va  |                  | Nader Tavakoli, M.  | o. 4000 i   | Mitchelly                            |                                 | Rđ.                  | #A31                  | 12                   | Bowie,                                     | MD.                        | 20716                         |                                    |        |
|             | Sta   |                  | 31. Date filed (Month, Day, Year)   | 2. Registrar's S  | Signature                            | R's                             |                      |                       |                      |  |                            |                               |                                    |        |
|             | Registr   | ar               | DEC 1 4 2005  | place 1   | to pro-                              |                                 |                      |                       |                      |  |                            |                               |                                    |        |

|                   |  |                | . For   |  |                                 |                                |   |                             |                      |            | lental Hyg                      | •                        | A 100 M        | 1 0 0 0 0  |
|-------------------|--|----------------|---|--|---------------------------------|--------------------------------|---|-----------------------------|----------------------|------------|---------------------------------|--------------------------|----------------|--|
|                   |  |                | 1 = State<br>Registrar  |  |                                 | Ce                             | rtificate                               | e of L                      | Death                |            | F                               | leg. No.                 | 05             | 42369  |
|                   | Physici  |                | 1. Decedent's Name (First, Middle   | e, Last)   |                                 |                                |   |                             |                      |            | 2. Date of Dea<br>Month         | th<br>Day                | Year           | 3. Time of Death                                   |
|                   | /Medi  |                | Madeline Marie  |  |                                 |                                |   |                             |                      |            | Decembe                         | er 9, 2                  | 2005           | 1:45 p M   |
|                   | Examir   | er             | 4a. Facility Name (If not institution   |  |                                 |                                |   |                             | Location of          | of Death   |                                 |                          | ty of Death    |  |
|                   |  |                | Crofton Conval  5. Social Security Number   |  |                                 | last birthday)                 |   | fton                        | If Under             | 24 Hrs     | 8. Date of Birtl                |                          | Arur           |  |
| Н                 | Funeral Director   |                | 213-16-9600   | 1□M 2∏F  | 84                              | Yrs.                           | Months                                  | Days                        | Hours                | Min.       | (Month, Day                     | , Year)                  |                | place (State or Foreign<br>ntry)                   |
|                   |  |                | Usual Residence of Decedent   |  | 04                              |                                |   |                             |                      |            | Oct. 14                         | +, 1921                  | Teni           | nessee   |
|                   | rrylan<br>nhow   | _              | 10a. State 10b. County  |  | 10c. Cit                        | y, Town or Lo                  | ocation                                 |                             |                      |            |                                 |                          |                | 10d. Inside City Limits                            |
|                   | Ba-1 g   | Director       |   | Arunde1  | Cro                             | ofton                          |   |                             |                      |            |                                 |                          |                | 1 X Yes 2 □ No                                     |
|                   | with the   |                | 10e. Street and Number  |  |                                 |                                | 10f. Zip                                |                             |                      |            |                                 | 10g. Citizen o           |                | ntry?  |
|                   | eath<br>rust   | erai           | 2131 Davidsonv  | ille Road  12. Was Decede                        | nt Ever in U                    | S 13                           |   | 113                         | snanic Ori           | gin? (Spe  | city Ves or No-                 | U.S.A.                   | ace - Ameri    | can Indian   |
| <b>'</b> O        | fter d   | by Funerai     | 1 ☐ Never Married 2 ☐ Marri   | Armed Force                                      | <u>ş</u> ş?                     |                                |   |                             |                      | , Puerto I | cify Yes or No-<br>Rican, etc.) | ВІ                       | ack, White,    | , etc.   |
| 8                 | ours a   | by             | 3 X Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Date                     | s:                              |                                | 1 ☐ Yes 2                               | 2 <b>I</b> ∑ No             | Specify:             |            |                                 | Spec                     | ify: Wh:       | ite  |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23e or 28e-f ahow<br>the McGraf Examinat must be invitited at  | Completed      | 15. Decedent<br>(Specify only highes  | t's Education                                    |                                 | 16a. Dece                      | dent's Usua<br>kind of wor<br>DO NOT us | Occupa                      | ition<br>Jurina mosi | t of worki | na                              | 16b. Kind of             | 3usiness/In    | ndustry  |
| 12                | within<br>ne.<br>han   | mpi            | Elementary/Secondary (0-12)   | College (1-4                                     | or 5+)                          |                                |   |                             | }                    |            |                                 |                          |                |  |
| р<br>В            | filed v<br>Hygie<br>ther 1   | Co             | 11. Father's Name (First, Middle,   | Last)  |                                 | Tarı                           | ff So                                   | rter                        | 18. Mothe            | ar's Name  | (First, Middle,                 |                          |                | c Corp.  |
| Maryland          | d be<br>ental<br>kad o   | To Be          | George William  |  |                                 |                                |   |                             |                      |            | Chenewot                        |                          | 1110/          |  |
| ary.              | should Mand Mark   | F              | 19a. Informant's Name/Relations   |  |                                 | 19b. Maili                     | ng Address                              | (Street a                   |                      |            | l Route Numbe                   |                          | ı, State, Zij  | Code)  |
| Š                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ta markad other than "natural", or Items 23e or 28a-f ahow any injury or other treumetic event, the Medical Examination in the reconstituted at 80ce.  |                | James N. Manue  | 1 Jr 9   | Son                             | 4038                           | Birc                                    | h Dr                        | ive,                 | Hunt       | ingtowr                         | , Mary                   | 1and           | 20639  |
| Baltimore,        | es 1 and He fitem  |                | 20a. Method of Disposition  1 X Burial 2 Cremation  | 3 Demoval from Sta                               | 20b. P                          | lace of Dispo<br>emetery, crea | sition (Nam                             | e of<br>her place           | a)                   | D          | ate                             | 20c. Location            | - City or T    | own, State   |
| Ĕ                 | Pag<br>ment<br>ant: I  |                | '4 ☐ Donation 5 ☐ Other (S  | pecify)  |                                 |                                |   |                             |                      |            |                                 |                          |                | Maryland   |
| 3a<br>H           | permit. Depart Import any inj  |                | 21. Signatur of F eral Service I  | Teensee  |                                 |                                |   |                             |                      |            | ch's Fu                         |                          |                |  |
|                   | 20 5 % OX  |                | ment Fallet   | May  |                                 |                                |   | _                           |                      |            | , Hyatt                         |                          | , MD           |  |
|                   |  |                | 23a. Párt . Enter the disease, or<br>show, or heart failure. List<br>Immediate Cause (Final | 1/4.   |                                 |                                |   |                             |                      | cardiac o  | r respiratory arr               | est,                     |                | Approximate<br>Interval Between<br>Onset and Death |
|                   | Physician /Medical   |                | disease (r condition resulting in death)  | a. Athero  |                                 |                                | eart                                    | Dise                        | ase                  |            |                                 |                          |                | Years  |
|                   | Examiner   |                |   | Hypert   | as a consequence of views       | ,                              | วางสุด                                  | cula                        | r Dic                | 20200      |                                 |                          |                | Years  |
|                   | di Men   | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying          |  | as a consequ                    |                                | 10 (45                                  | cula                        | I DIS                | case       |                                 |                          |                | rears  |
|                   | icutec<br>nd<br>Iransi   | Examiner       | Cause (Disease or injury that initiated events  | c  |                                 |                                |   |                             |                      |            |                                 |                          |                |  |
| 8760,             | ate be executed<br>hysician and<br>the burial-transit  | EX             | resulting in death) Last  | Due to (or                                       | as a consequ                    | uence of):                     |   |                             |                      |            |                                 |                          |                |  |
|                   | Attending Physician: The law requires that the death certificate be executed r death.  r death. ector: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit  | dicai          |   | d  |                                 |                                |   |                             |                      |            |                                 |                          |                |  |
| 9 x               | es that the death certific<br>igned by the attending p<br>be detached for use as   | Physician/Med  | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcor                              | ne of pregna                    | ncy                            |   |                             |                      |            |                                 | 23d D                    | ate of delive  | any  |
| Вох               | death<br>a atter<br>d for u  | iciar          | in the past 12 months?  | 1 ☐Live birth<br>4 ☐ Pregnani                    | 2 Fetal                         | Ideath 3                       | Ectopic pre Other (spe                  |                             |                      |            |                                 |                          | onth           | Day Year   |
| P.O.              | t the c<br>by the<br>acheo   | hysi           | 9 Unknown   | 9□ Unknowr                                       | 1                               |                                |   |                             |                      |            |                                 |                          |                |  |
|                   | gned<br>gned<br>oe del   | by P           | Part II. Other significant condition  | ns contributing to deat                          | n but not resu                  | ulting in the u                | nderlying ca                            | use give                    | n in Part I.         |            | 23e. Did to                     | pacco use cor            | tribute to the | he cause of death?                                 |
| Records,          | w require<br>been si<br>should t   | ted            |   |  |                                 |                                |   |                             |                      | _          | 1 □ Y                           | es 2∭No                  | 3 Prob         | pably 4 Unknown                                    |
| ec                | law r<br>las be<br>s 2 sh  | Completed      |   |  |                                 |                                |   |                             |                      |            | 24a. Was a                      | V                        | Were auto      | psy findings available<br>mpletion of cause of     |
|                   | : The cate h   | Con            |   |  |                                 |                                |   |                             |                      |            | perform<br>1 ☐ Yes              |                          | death?         |  |
| Ĭž.               | sician: The law<br>certificate has E<br>irector, page 2 s  | Be             | 25. Was case referred to medical examiner?  | Hospital:  |                                 |                                |   | A Othe                      |                      |            | (Check only on                  |                          |                |  |
| o                 | Phys<br>r this<br>ral dii  | . To           | 1 Yes 2 No  | 1 ☐ Inpa   |                                 | ER/Outpatier<br>28b. Time of   |   |                             | 720 1401             |            | ne 5 Reside                     |                          |                | y)   |
| on                | nding<br>th.<br>: Afte<br>e fune   | tlon           | 1 XNatural 5 ☐ Pending<br>2 ☐ Accident investig   | g (Month, i                                      | Day Year)                       | Injury                         | м                                       | Bc. Injury<br>Work<br>1 🗆 Y | ?<br>'es 2 ☐ h       |            |                                 | ow injury cood           | 100            |  |
| Division of Vital | Atternation of the part of the | ifica          | 3 Suicide 6 Could n   | inca   286. Place of                             | Injury - At ho<br>etc. (Specify | me, farm, str                  | eet, factory,                           | office                      |                      | 2          |                                 |                          | ber or Rura    | al Route Number,                                   |
|                   | tal or<br>rs afte<br>al Dira   | Certification: | Tromede   | Building,  | etc. (Specify                   | ·/                             |   |                             |                      | 1          | City or Town                    | i, State)                |                |  |
|                   | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page  |                | (Check only 2 Medical E   | g Physician: To the be<br>Examiner: On the basis | st of my knows                  | wledge, death                  | n occurred a                            | it the time                 | e, date and          | d place, a | nd due to the c                 | ause(s) and m            | anner as st    | tated.   |
|                   | To the within 2. To the I complet  | Medical        | one) 29b. Signature and title of certifier  | and manner                                       | stated.                         |                                |   | License                     |                      |            |                                 |                          |                |  |
|                   | Z × Z  | _              | ,   | sh ov  | 10/10                           | M                              | 1                                       |                             | 20108                |            |                                 | 9d. Date signo<br>Decemb |                |  |
| Л                 | (n)  |                | 30. Name and address of person  |  |                                 |                                | •                                       | 200.                        | ~0100                |            |                                 | Decemb                   | >T 13          | , 2005   |
| L                 |  |                | Rakesh Arora, N   |  |                                 |                                |   | ne. !                       | Suite                | 222        | , Bowie                         | . Marv                   | land           | 20715  |
|                   | Sta  |                | 31. Date filed (Month, Day, Year)   | 3 Regi   | strar's Signa                   | ture                           |   | <b>,</b>                    |                      |            | , DOWLE                         | , y                      | Land .         | <u> </u>   |
|                   | Registr  | ar             | DEC 142   | 005  | 2                               | And                            | W.                                      |                             |                      |            |                                 |                          |                |  |

|                   |   |                | For State Registrar  |                                     | State of M   | aryland /            |            | rtment of F<br>rificate of I                 |                              | nd Mental H                            | giene (                        | 05                     | 42370                                     |
|-------------------|---|----------------|--|-------------------------------------|--|----------------------|------------|--|------------------------------|--|--------------------------------|------------------------|---|
|                   |   |                | Decedent's Name (Fire  | st, Middle, Last)                   | ···-   |                      |            |  |                              | 2. Date of D                           | eath                           |                        | 3. Time of Death                          |
|                   | Physici<br>/Medi  |                | Daniel   | Ro                                  | bert   | Moren                | 10         |  |                              | Decemb                                 | er 09, 2                       | 2005                   | 4:43 P M                                  |
|                   | Examir  |                | 4a. Facility Name (If not i  | _                                   |  | )                    |            | 4b. City, Town, or                           |                              | Death                                  | 4c. Coun                       | ty of Death            |   |
|                   |   |                | Suburbar   |                                     |  |                      |            | Bethe  |                              |  |                                | ontgor                 | mery                                      |
|                   | Funeral<br>Director   | ſ              | 5. Social Security Number 600-22-2523  |                                     | 7. Ag  | ge (In yrs. last bi  | Yrs.       | If Under 1 Year<br>Months Days               | If Under 24<br>Hours         | Min. (Month, D                         | irth<br>Pay, Year)<br>.1, 1982 | 9. Birth<br>Cou<br>Ari | place (State or Foreign<br>ntry)<br>.ZONA |
|                   | pus   |                | Usual Residence of Dece<br>10a. State 10b.   | dent<br>County                      |  | 10c. City, Tow       | wn or Loc  | ation  |                              |  |                                |                        | 104 1-14 02 11-2                          |
|                   | Aarylan<br>f show   | 5              |  | ,                                   |  |                      |            | 20011  |                              |  |                                |                        | 10d. Inside City Limits 1∑Yes 2 □ No      |
|                   | the t   | Director       | AZ<br>10e. Street and Number   |                                     |  | Tuc                  | son        | 10f. Zip Code                                |                              |  | 10g. Citizen of                | What Cou               |   |
|                   | 3a or   |                | 4477 N. Sum  | mersett                             | Loop   |                      |            | 85750  | ı                            |  | USA                            |                        | noy.                                      |
|                   | death   | nera           | 11. Marital Status   |                                     | 2. Was Decedent  | Ever in U.S.         | 13. W      |  |                              | ? (Specify Yes or Noverto Rican, etc.) |                                | ce - Ameri             |   |
| 920               | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or itams 23s or 28s-f show other traumatic svent, the Modical Examinar must be notified at   | by Funeral     | 1 XNever Married 2<br>3 Widowed 4 D  |                                     | Armed Forces:<br>1 Yes 2 3<br>If Yes, Give<br>Year or Dates: |                      |            | Yes, specify Cuba<br>☐ Yes 2 XNo             | n, mexican, F<br>Specify:    | rueno Hican, etc.)                     | Spec                           | ack, White,<br>ity:    | etc.<br>ite                               |
| 200               | 72 ho   | ted            | 15. E  | Decedent's Educ<br>ly highest grade | cation   | 16a                  | . Decede   | nt's Usual Occup                             | ation                        |  | 16b. Kind of I                 |                        |   |
| 21215-0036        | 2 should be filed within 7<br>and Mental Hygiene.<br>Is marked other than **<br>aumatic svent, the Med  | Completed      | Elementary/Secondary   |                                     | College (1-4or   | 5+)                  |            | ind of work done of NOT use retired nemploye |                              | rworking                               | none                           |                        |   |
| b                 | be filed<br>ital Hygie<br>d other<br>event, it  | BeC            | 17. Father's Name (First,  | Middle, Last)                       |  |                      |            |  |                              | Name (First, Middle                    |                                | me)                    |   |
| Maryland          | should b<br>nd Ments<br>marked  | To E           | Robert More  | eno                                 |  |                      |            |  | Su                           | san Hoove                              | r                              |                        |   |
| lan               | 2 sho<br>and is ma  |                | 19a. Informant's Name/P  | lelationship (Ty)                   | oe, Print)   | 198                  | o. Mailing | Address (Street a                            | and Number o                 | or Rural Route Numi                    | per, City or Town              | , State, Zip           | Code)                                     |
|                   | 1 and 2<br>Health :<br>tsm 27 i   |                | Susan Moreno   |                                     | <u>-</u>   |                      |            | N. Summe                                     | rsett                        |  | uscon,                         |                        |   |
| Baltimore,        | 8 = 5   |                | 20a. Method of Disposition<br>1 ☐ Burial 2 🖾 Cre   | mation 3 □R                         | emoval from State  |                      | ry, crema  | tion (Name of<br>tory or other plac          | e)                           | Date                                   | 20c. Location                  | - City or To           | own, State                                |
| Ę                 | nit. Pag<br>partment<br>cortant: I<br>injury o  |                | 4 □ Donation 5 □ 0 21. Signature of Funeral  |                                     |  | E1 En                |            | Memori                                       |                              | 2-17-2005                              | Tucsor                         | ı, AZ.                 |   |
| Ba                | permit. Departm Importate sny injure once.  |                | 1 Q.P.   | Mar                                 | chall  | 2                    | 42         | 17 9th S                                     | t. N.W                       | al Home,<br>Washin                     | gton, Do                       | C_200                  | 11  |
| П                 |   |                | 23a. Park. Enter the dis<br>shock, or heart failu  | ease, or compli<br>re. List only on | e cause on each li   | d the death. Do ine. | not enter  | the mode of dying                            | g, such as car               | rdiac or respiratory                   | arrest,                        |                        | Approximate<br>Interval Between           |
|                   | Physician   |                | Immediate Cause (Final disease or condition resulting in death)  | _ a                                 | <i>I</i> ſ   | WHI                  | ) (e       | this   | unei                         | 4                                      |                                |                        | Onset and Death                           |
|                   | /Medical<br>Examiner  |                | rosulting in south,  | •                                   | Due to (or as  | a consequence        | of):       | /  |                              |  |                                |                        |   |
|                   |   | er             | Sequentially list condition  | ns, b                               | Due to for as  | ā turiseduance       | of).       |  |                              |  |                                |                        |   |
|                   | uted<br>d<br>ansit  | Examin         | if any, leading to immedia<br>cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events | - ⊀.                                |  |                      | ,          |  |                              |  |                                |                        |   |
| ó                 | an an<br>rial-tr  | Exa            | resulting in death) Last   | ٥                                   | Due to (or as  | a consequence        | of):       |  |                              |  |                                |                        |   |
| 68760,            | ificate be executed<br>g physician and<br>as the burial-transit   | edicai         |  | d                                   |  |                      |            |  |                              |  |                                |                        | 5/a3-                                     |
|                   | e as t  | Med            | IF FEMALE:   |                                     |  |                      |            |  |                              |  |                                |                        | -   |
| .O. Box           | The law requires that the death certifi<br>vie has been signed by the attending<br>bage 2 should be detached for use as   | Physician/M    | 23b. Was decedent pregint the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                     | Idill                               | Sc. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown  | 2 Fetel death        |            | ctopic pregnancy<br>Other (specify)          |                              |  |                                | ate of delive<br>onth  | ery<br>Day Year                           |
| Δ.                | that in the plant |                | Part II. Other significant   | conditions con                      | Inbuting to death b  | ut not resulting i   | n the und  | erlying cause give                           | n in Part I.                 | 23e. Did                               | tobacco use con                | tribute to th          | ne cause of death?                        |
| rds               | w requires<br>been sign<br>should be  | ed by          |  |                                     |  |                      |            |  |                              | 10                                     | Yes 2 No                       | 3 🗆 Prob               | ably 4 Dunknown                           |
| of Vital Records, | e law requ<br>has been<br>je 2 shoul  | Completed      |  |                                     |  |                      |            |  |                              | 24a. Was                               |                                | Were auto              | psy findings available                    |
| <u>ت</u>          |   | Com            |  |                                     |  |                      |            |  |                              |  | ormed?                         | death?                 | mptetion of cause of<br>2□ No             |
| /ita              | Physician: T<br>this certificet<br>ral director, pa   | Be             | 25. Was case referred to examiner?   |                                     |  |                      |            |  |                              | Death Check only                       | one)                           |                        |   |
| of                | Phys<br>this<br>al di   | ဥ              | 1 XYes 2 No<br>27. Manner of Death   | H                                   | ospital:<br>1 ☐ Inpatie                                      |                      |            | 3□ DOA Othe                                  | 4 U Nursir                   | ng Home 5 ☐ Res                        |                                |                        | y)  |
| O                 | ding<br>h.<br>After<br>fune   | ton            | 1 Natural 5  | Pending                             | 28a. Date of Inju  | y Year) 280.         | Time of    | 28c. Injury<br>Work                          | at<br>?<br>′es 2 <b>X</b> No | 28d. Describe                          | how injury occur               | red                    | 6/1                                       |
| Division          | tten<br>deat<br>tor:  | fica           | 1  | Could not be determined             | 28e. Place of trij   | ury - At home, fa    | rm. stree  |  | 63 2010                      | 28f Location                           | Street and Numi                | THE OF BUR             | Bours Number                              |
| ă                 | al or /<br>s efter<br>il Dirs<br>id in b  | Certification: | 4 Homicide   | derennined                          | building, et   | (Specify)            | ch         | (11-   | NIH                          | City or To                             | wn, State)                     | = Dic                  | e   |
|                   | Hospital  |                | 29a. Certifier 1 ☐ C   | Certifying Phys                     | ician: To the best   | of my knowledge      | e, death o | ccurred at the tim                           | e, date and p                | lace, and due to the                   | cause() and m                  | anner as st            | ated.                                     |
|                   | To the Hospital or Al<br>within 24 hours efter of<br>To the Funeral Direc<br>completely filled in by  | Medical        | one)   | redical Examin                      | and manner st  | examination an       | wor inve   | stigation, in my op                          | inion, death o               | occurred at the time,                  | date and place                 | and du to              | the cause(s)                              |
|                   | To To   | 2              | 29b. Signature and title of  | certifier                           | 1110   |                      |            | 29c. License                                 |                              |  | 29d. Date signe                |                        |   |
| ,                 |   |                | 1)   | uste                                | elle   |                      |            |  | O.C.M.                       | Ε.                                     | Decembe                        | r 10,                  | 2005                                      |
| e                 | 10)   |                | J-14/201   | 1 loc                               | npleted cause of d   | eath (Item 23a)      |            |  | eet, B                       | Baltimore,                             | Maryla                         | nd 21:                 | 201                                       |
|                   | Sta<br>Registr  |                | 31. Date filed (Month, Day   | 4 2005                              | 2. Registr   | ar's Signature       | fiel       | وع   |                              |  |                                |                        |   |

|  |   |                   | 1 - For State Registrar   | State of Maryla  |  | artmen<br>rtificate       |                         | ealth an                                  |                             | tal Hygien                                     | 2005                         | 42371  |
|--|---|-------------------|---|--|--|---------------------------|-------------------------|---|-----------------------------|--|------------------------------|--|
|  | Physic<br>/Medi   |                   | 1. Decedent's Name (First, Middle, Last) Ryan Niexandar   | utchell  |  |                           |                         |   |                             | Date of Death                                  | ay Year                      |  |
|  | Exami   | ner               |   | al Hospital  |  | Oln                       | iey                     | Location of D                             |                             | M  | c. County of Deal            |  |
|  | Funeral<br>Director   |                   | Usual Residence of Decedent   | 7. Age (In yrs   | s. last birthday)<br>Yrs.                        | If Under<br>Months        | Days                    | Hours 1                                   | Min /                       | Date of Birth<br>Month, Day, Year<br>ECEMBEY 1 | 6 2065 M                     | nthplace (State or Foreign ountry)                 |
|  | e Maryland<br>3e-f ahow<br>Litied at  | ctor              | 10a. State 10b. County  |  | City, Town or Lo                                 |                           | Tou                     | UN  |                             |  |                              | 10d. Inside City Limits 1 Yes 2 No                 |
|  | 72 hours after death with the Maryland<br>natural', or Itama 23a or 28e-f ahow<br>dical Exatua at must be notified at   | Funeral Director  | 10e. Street and Number  3948 DEER  11. Marital Status   | TRAIL. Was Decedent Ever in I  | Way  |                           | 113                     |   |                             |  | itizen of What C             | A  |
| 5-0036   | ours after d<br>ral', or Itam   | b                 | 1 Never Married 2 Marned 3 Widowed 4 Divorced   | Armed Forces?  1 Pes 2 No If Yes, Give Year or Dates:                    | If   | Yas Deced<br>Yes, spec    | ,                       | panic Origin'<br>, Mexican, P<br>Specify: | ? (Specify '<br>uerto Ricar | Yes or No-<br>n, etc.)                         | 14. Race - Ame<br>Black, Whi | erican Indian,<br>te, etc.                         |
| 1215-0   | within<br>ane.<br>than  | Completed         | 15. Decedent's Educa<br>(Specify only highest grade<br>Elementary/Secondary (0-12)                          | completed) College (1-4or 5+)  | 16a. Deced<br>(Give life. D                      | kind of wor<br>OO NOT us  | k done du<br>e retired) | iring most of                             | working                     |  | Kind of Business             |  |
| land 2   | ould be filed wental Hygis<br>Mental Hygis<br>arkad other<br>atto avant, It   | To Be Co          | 17. Father's Name (First, Middle, Last) RAMON Alexa   | nder M   | itche  |                           |                         | 18. Mother's                              | Name (Firs                  | SI, Middle, Maidei                             | INFA                         | wartz  |
| , Mary   | and 2 should<br>ealth and Men<br>m 27 le marka<br>ser traumatic   |                   |   |  |  |                           | 1                       | nd Number o                               | TRA                         | ite Number, City                               | or Town, State,              | Zip Code)  |
| <b>Baltimore</b>   | Pa<br>First   |                   | 20a. Method of Disposition  1 Burial 2 Cremation 3 Ref 4 Donation 5 Other (Specify)                         | noval from State   | Place of Dispos<br>cemetery, crem<br>on + on \\\ | -Vy U                     | Her place)              | a   20                                    | JAN 2                       | -01  | ocation - City or<br>Ney N   | Town, State  |
| Ba   | Permit. Departre Importe any Inte   |                   | 21. Signature of Funeral Service Licensee   | tions that caused the dea  | Ma   | Name and                  | merc                    | 1 Gen                                     | reval                       | Hosptal  | 1810<br>Olney                |  |
|  | Physician<br>/Medical   | 8 1               | hoc or heart failure. List only one immeriate Cause (Final disea to condition resulting in death) a.        | cause on each line.  Extreme  Due to (or as a consec                     | Premat   | 3                         | or dying,               | Such as care                              | alac or resp                | orratory arrest,                               | 194                          | Approximate Interval Between Onset and Death Union |
| 10   | Examiner  | Iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consec   |  |                           |                         |   |                             |  |                              |  |
| 8760,  | ate be executed hysician and the burial-transit   | ai Examiner       | Cause (Disease or injury that initiated events resulting in death) Last                                     | Due to (or as a consec   | quence of);                                      |                           |                         |   |                             |  |                              |  |
| Box 687  | ate<br>hy   | Physician/Medical | d.  IF FEMALE: 23b. Was decedent pregnant 23c   | If yes, outcome of pregna  | ancv   |                           |                         |   |                             |  |                              |  |
| P.O. B   | it the de th<br>by the atte   | hysicia           | in the past 12 months?  1 Yes 2 No 9 Unknown  | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d<br>9 ☐ Unknown      | aldeath 3 ⊟8                                     | Ectopic pre<br>Other (spe |                         |   |                             |  | 23d. Date of deli<br>Month   | very<br>Day Year                                   |
| ords, F  | The law requires that the death certific te has been signed by the attending page 2 should be detached for use as:  | þ                 | Part II. Other significant conditions contri  | outing to death but not res  | sulting in the und                               | derlying car              | use given               | in Part I.                                | 2                           |  |                              | the cause of death?                                |
|  |   | Completed         |   |  |  | _                         |                         |   | -                           | 4a. Was an autopsy performed?  ☐ Yes 2☑ No     | death?                       | topsy findings available completion of cause of    |
| of Vita  | Physician<br>this certifi<br>al director  | : To Be           | 25. Was case referred to medical examiner? 1 □ Yes 2 No Hos 27. Manner of Death                             | 1 p⊿ Inpatient 2 □   | ER/Outpatient                                    |                           | Other:                  |   | Home 5                      | Residence                                      |                              | uty)   |
| /ision   | To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director; After this certificacompletely filled in by the funeral director. | Certification:    | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                             | 28a. Date of Injury<br>(Month, Day Year)<br>28e. Place of Injury - At ho | 28b. Time of Injury                              | М                         |                         | s 2 No                                    |                             | escribe how injur                              |                              |  |
| Ö  | ospitel or A<br>hours after<br>unerel Direc<br>ly filled in by  |                   | 29a. Certifier 1 Certifying Physici   | building, etc. (Specification)   | y)<br>owledge death                              | accurred at               | the time                | date and pla                              | Ci                          | ty or Town, State                              | )                            | ral Route Number,                                  |
|  | To the Hospitel within 24 hours a To the Funerel Completely filled  | Medical           | one)  | Off the basis of examina   | mon and/or mve                                   | stigation, ir             | i my obini              | ion, death oc                             | curred at the               | he time, date and                              | place, and due               | to the cause(s)                                    |
|  |   |                   | 30. Name a d ddress of us son who comp  | leted cause of death (Item   | n 23a) (Type, Pr                                 | rint)                     | 000                     | 6174                                      | -9                          | 12/  | 116/05                       |  |
| 90<br>100<br>100<br>100<br>100<br>100<br>100<br>100<br>100<br>100<br>1 | Sta<br>Registra   | 4.0               | Gillan Yeo, MD  31. Date filed (Month, Day, Year)   | leted cause of death (Item 61) 30A6 32. Registrar signa                  | ita Wa   | 0 600                     | Silver.                 | - Sprii                                   | 19, 1                       | 4D 2091  | 01                           |  |
| 30   | riegistra   |                   | DEC 2   | y Luuro  | 16.7 20.   | 19                        | 55-5-5                  |   |                             |  |                              |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 42372 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Year **Physician** 04 10:00 DM 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** 7. Age (In yrs. last birthday) Somes If Under 1 Year | If Under 24 Hrs 8. Date of Birth 2-06-1948 5. Social Security Number 6. Sext 1 ☐ M 2 ☐ F 9. Birthplace (State or Foreign **Funeral** Months Days Hours 57 219-46-6760 WASHINGTON, DC Director Usual Residence of Decedent with the Maryland wohe 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23a or 28a-f ehov the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD CHARLES WALDORF 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 11860 OAK MANOR DRIVE 20609 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Depertment of Heelth and Mental Hygiene important: if Itam 27 is marked other than "naturel; or Itan any Injury or other treumatic event, the Medical Ferral 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ Specify: 3 Widowed 4 Divorced BLACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER METRO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARY BURGESS CLAYTON NEAL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WIFE 11860 OAK MANOR DRIVE, WALDORF, MD BASHIE LOCKHART-NEAL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State RIVERDALE PARK CREM. 12/7/05 RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign wire of Funeral Service Licenses 22. Name and Address of Facility RONALD TAYLOR, II FUNERAL C. 10583 MIDDLEPORT LANE, WHITE PLAINS, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** arcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physicien: The law requires thet the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ned by the attending physicien detached for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ★ No 24a. Was an certificete 2X No 28 No 1 Yes within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. D te of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide To the Hospital within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time. Jate and plane, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person

31. Date filed (Month, Day, Year)

Suresh

UEC U 9 2005

ratts Rel clinton-MD20735

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Katel m D

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Nancy O'Neill 5:15 <sup>a M</sup> Louise December 13, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13912 Rippling Brook Drive Montgomery Silver Spring If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ XF Director June 22, 1944 Canada 61 214-70-1755 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits worle 10a State 10b. County in than "natural", or iteme 23a or 28e-f ehove the Medical Examinar must be notified at 1 Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 USA 13912 Rippling Brook Drive death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite eny injury occuper traumatic event, the Medical Examinations. 1 Never Married 2XXMarried Specify White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 🍇 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Internet Security 4 Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mona McHale Norman Herod 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13912 Rippling Brook Drive, Silver Spring, MD 20906 Geoffrey O'Neill/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December 14 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Metropolitan Crematory Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Adress Cortins Funeral Home Inc. . -500 University Blvd, W, Silver Spring, MD 20901 2h 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 26 Months Small Cell Lung Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury Due to (or as a consequence of): Examiner requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2√XNo 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificete has t firector, page 2 s autopsy performed? 1 Yes 2 🔀 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after deat 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funerel I 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 13, 2005 D29675 person who completed cause of death (Item 23a) (Type, Print) 6420 Rockledge Drive, Suite 4100, Bethesda, MD 20817 Ralph Boccia, M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2005

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|                              |   | •                     | For<br>State<br>Registrar   | State of Man   | •                            | epartment o<br>Certificate o               |   | •   | giene<br>Reg. No.            | 05  | 42374  |
|------------------------------|---|-----------------------|---|--|------------------------------|--|---|---|------------------------------|---|--|
|                              | Physicia  | an                    | Decedent's Name (First, Middle,  MADY CHI   | Last) RISTINE PRO  | CARTO                        |  |   | 2. Date of De<br>Month<br>DECEMBI         |                              | 200 <sup>Yeer</sup>                               | 3. Time of Death 3:35 AM                           |
|                              | /Medic<br>Examin  |                       | 4a. Facility Name (If not institution,  | give street and number)  |                              |  | n, or Location of Deat                          | th  | 4c. Co                       | unty of Death                                     |  |
|                              |   |                       | CARROLL LUTHERAN  5. Social Security Number   |  | THCARE                       |  | WESTMINSTE<br>Dar If Under 24 Hrs               |   |                              | RROLL   | place (State or Foreign                            |
|                              | Funeral<br>Director   |                       | 301–16–9195   | 1□MXXIF 81   |                              | Months Da                                  |   |   | Y Y 92                       | 4 OHIO  | intry)   |
|                              | ryland<br>thow  |                       | Usual Residence of Decedent  10a. State 10b. County   | 11   | Oc. City, Town o             | r Location                                 |   |   |                              |   | 10d. Inside City Limits                            |
|                              | 8a-fa   | ecto                  | VA ALEXA  | IDRIA  | ALEX                         | ANDRIA                                     |   |   | 10 011                       | (1111 . 0   | 1 □XYes 2 □ No                                     |
|                              | th with ti  | ai Dire               | 10e. Street and Number 5708 HELMSDA   | ALE LANE   |                              | 10f. Zip Cod                               | 315   |   | U.S                          | of What Cou<br>• A •                              | intry?   |
| PROCARIO                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Departiment of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Health and Health and Health and Indianal and Indianal Examination of the multiple at page. | 1 by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced   | 12. Was Decedent Eve<br>Armed Forces?<br>1 Yes 2 No<br>If Yes, Give<br>Year or Dates:      |                              | 1 ☐ Yes 2 🛣                                |   |   |                              | Race - Amen<br>Black, White,<br>pecify: WH        | , etc.   |
| 2                            | 72 h  | etec                  | 15. Decedent's (Specify only highest  | Education<br>grade completed)  | 16a. D                       | ecedent's Usual Oc<br>Sive kind of work do | cupation<br>one during most of wo<br>tired)     | erking                                    | 16b. Kind                    | of Business/In                                    | ndustry  |
| 0.12                         | ed within<br>giene.<br>er than  | Completed             | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                              | HOMEM                                      |   |   | HO                           | MEMAK   | TNG  |
| RIC                          | e filed<br>other<br>vent,   | Be C                  | 17. Father's Name (First, Middle, L.  | ast)   |                              |  |   | me (First, Middle                         |                              |   | 1110   |
| CA                           | Mental<br>Mental<br>arked c   | To                    | SAVERIO   |  |                              |  | CELE  |   | ANCA                         |   |  |
| PROCARIO<br>Maryland 21      | nd 2 sh<br>lith and<br>27 is m<br>r traum   |                       | 19a. Informant's Name/Relationshi<br>ANGELA C. PROC   |  | GHTER                        | lailing Address <i>(Str</i><br>2801 AR     | eet and Number or R<br>TERS MIL                 | ura <i>l R</i> oute <i>Numb</i><br>LRD, V | er, City or To<br>VESTM      | nwn, State, Zip<br>INSTE]                         | <sup>o Code)</sup> 21158<br>R, MD                  |
| ARY C.                       | Pages 1 ar<br>nent of Hea<br>int: If Item<br>irry or othai  |                       | 20a. Method of Disposition 1 ☐ Burial ②X Cremation 4 ☐ Donation 5 ☐ Other (Sp.  | 3 □Removal from State  | 20b. Place of D<br>cemetery, | isposition (Name of crematory or other     | place) 12/                                      | 1 <sup>Date</sup> /200                    | <i>y</i>                     | ion - City or To                                  |  |
| MARY                         | permit. Pag<br>Department<br>Important: I<br>any injury o   |                       | *4 □ Donation 5 □ Other (Sp. 21. Sunature of Funeral Service L  | icensee  | OTH CA                       | 22. Name and Ad                            | dress of Facility                               | ELINIEU S. I                              |                              | FIELD   | , MO   |
| MA                           | 80 5 8 8  |                       | 23a. Part I. Enter the disease, or o  | M  | 01191                        | 91 WILL                                    | URBORAW<br>IS ST. W                             | FUNERAL<br>ESTMINS                        | TER,                         | MD  | 21157  |
|                              |   |                       | ck, or heart failure. List o  | nly one cause on each line.  | e death. Do no               | enter the mode of                          | oying, such as camia                            | c or respiratory a                        | rrest,                       |   | Approximate<br>Interval Between<br>Onset and Death |
|                              | Physician -<br>/Medical   |                       | disease or condition resulting in death)  | a. End Se<br>Due to (or as a c   | onsequence of)               | engere                                     | ue Hee  | we 1-0                                    | nn                           | -   | Smer   |
|                              | Examiner  | <u>.</u>              | Sequentially list conditions,   | b. Sever   | e Pul                        | many                                       | Dygerse   | ensur                                     | _                            |   | 3mes   |
|                              | cuted<br>id<br>ansit  | Examiner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | · CANI   | 13-81                        | W C  | , 0   |   |                              |   | lun  |
| 9                            | ificate be executed<br>g physician and<br>as the burial-transit   | ai Exa                | resulting in death) Last  | Due to (or as a c  |                              |  | e hem   | Dise                                      |                              |   |  |
| 68760                        | g physias the   | edicai                |   | d. Sprov   | wear                         | * TUCKU                                    | ol Mun  | Vinsee                                    | m                            |   | my -   |
| O BOX                        | eath cert<br>attendin<br>for use  | by Physician/M        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown                 | Fetal death                  | 3 ☐ Ectopic pregna<br>5 ☐ Other (specify   |   |   | 23d                          | . Date of delive<br>Month                         | ery<br>Day Year                                    |
| ٥                            | uires that<br>signed b  | d by Ph               | Part II. Other significant condition  | is contributing to death but r   | not resulting in t           | ne underlying cause                        | given in Part I.                                |   | obacco use<br>Yes 2 N        |   | the cause of death?                                |
| Olivicion of Vital Becorde D | ysiclan: The law require is certificate has been sidirector, page 2 should the  | Completed             |   |  |                              |  |   | 24a. Was<br>auto<br>perfo<br>1 Yes        |                              | 4b. Were auto<br>prior to co<br>death?<br>1 □ Yes | opsy findings available impletion of cause of      |
| <u> </u>                     | iclan:<br>certific  | Be                    | 25. Was case referred to medical examiner?  | Hospital:  |                              |  | Other -   | ath (Check only o                         |                              |   |  |
| 7                            | Attanding Physician: r death. actor: After this certific. by the funeral director,  | n: To                 | 1 Yes 2 No 27. Manner of Death  | 28a. Date of Injury (Month, Day Y  | 2 ER/Outp                    | ne of 28c. I                               | niury at  | Home 5 ☐ Resi<br>28d. Describe            |                              |   | fy)  |
| <u></u>                      | anding<br>ath.<br>or: Afte  | atio                  | 1 Natural 5 Pending 2 Accident investiga  | ation  | 'ear) Inju                   |  | Work?<br>1 □ Yes 2 □ No                         |   |                              |   |  |
| Divio                        | al or Attu<br>after de<br>I Diractu<br>d in by ti   | Certification:        | 3 Suicide 6 Could n<br>4 Homicide determin  |  |                              | , street, factory, offi                    | ice   | 28f. Location (<br>City or To             | Street and N<br>wn, State)   | umber or Rura                                     | al Route Number,                                   |
|                              | Hospi<br>4 hou<br>Funer<br>ely fill   | edicai C              | 29a. Certifier (Check only one)  Certifying  2 Medicel F  | Physicien: To the best of market of the basis of examiner; On the basis of examiner stated | camination and/              | eath peopred at the primy estigation, in n | e time, date and plac-<br>ny opinion, death occ | e, and due to the<br>urred at the time,   | cause(s) and<br>date and pla | d manner as s                                     | stated.<br>o the cause(s)                          |
|                              | To the Within 2 To the complete   | Ž                     | 29b. Signature and title of pertifier   | 16   |                              | //   | ense number                                     |   |                              | igned (Month,                                     |  |
|                              | WIS   |                       | •   | 1)//   | MI                           | 7  | 37949   |   | Dec.                         | ath 2   | 005.   |
|                              | 15  |                       | 30. Name and address of person was ALEXANDER BO   |  | v                            |  | ST LANE,  | WESTW                                     | INST                         | ER, MI  | D21157   |
| 1                            | Sta<br>Registr  |                       | 31. Date filed (Month, Day, Year)   | 32. Registrar's 2 2005   | Signature                    | South                                      | •   | WEST                                      | TTAND T                      | <u> </u>  | <u> </u>   |
|                              |   |                       | 250 1   | ~ COOA   | 10                           | (A)CALL)                                   |   |   |                              |   |  |

State of Maryland / Department of Health and Mental Hygien For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 10:30AM 10 -05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 17007 Horsehead Rd Brandywine Pr If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Prince Georges
Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2√2 F 94 Yrs. March 26,1911 Director Maryland 220-62-7495 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 XYes 2 No MD Prince Georges Directo Brandywine 10g. Citizen of What Country? 10e. Street and Number 17007 Horsehead Rd 10f. Zip Code 20613 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specity: Specify: Black þ 3X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Prince Georges Elementary/Secondary (0-12) College (1-4or 5+) County Government 12 Aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill thent of Health and Mental H tant: If Item 27 Is marked ott jury or other traumatic even Be Thomas Savoy Luvenia Riley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17007 Horsehead Rd, Brandywirle, Md 206 ace of Disposition (Name of Date 20c. Location - City or Town, State Rhodena Dorsey Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Resurrection permit. Page Department of Important: if any injury or once. 12/17/05 Clinton, Md 21. Signature 22. Name and Address of Facility 20605 Aquasco Rd. Adams Funeral Home, Aquasco, MD 20608 was 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THEROSILEROT **Physician** 4Bgv /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical use as 1 IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ፩ 2 No. 3 Probably 4 Unknown certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a, Was an autopsy performed? 2 1 ☐ Yes Hospital or Attending Physician: After this certification, in 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1€N6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: K Natural 5 Pending n 24 hours after death.

Funara! Director: Afteletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier fire cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai within 24 hou To the Funa completely fi and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of cortif 29c. License number 12/01 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

701 halling Tran

32. Registrar's Signature

GAN

DEC 1 5 2005

31. Date filed (Month, Day, Year)

| Physici<br>/Media  |   | 1. Decedent's Name (First, Middle, Las   | t)   |   |   |  | 2. Date of De<br>Month   | eath<br>Day  | year 3. Tim   | e of Death   |
|--|---|--|--|---|---|--|--|--|---|--|
|  |   | Cassandra Pric   | de   |   |   |  | Novemb   |  |   | 5 P M  |
| Examir   |   | 4a. Facility Name (If not institution, give  |  |   | 1   | wn, or Location of De  | eath   |  | nty of Death  |  |
| <i>(</i> -,  |   | Railroad tracks near 2  5. Social Security Number 6. Se  |  | nd Avenue<br>je (In yrs. last birthd  |   | ersburg  | Irs. 8 Date of Bi  |  | ntgomery  9. Birthplace (Sta  | to or Foreign  |
| uneral<br>irector  |   |  |  | 43 Yrs  | Months [  |  | 8. Date of Bi<br>(Month, Di<br>01-31-  | ay, Year)<br>-1962   | Washingto   |  |
| No W   |   | 10a. State 10b. County   |  | 10c. City, Town o   | r Location  |  |  |  | 10d. Insid  | e City Limits  |
| 투표   | to  | D.C.   |  | Wash  | nington   |  |  |  | 120   | res 2 □ No   |
| r 28a  | lrec  | 10e. Street and Number   |  |   | 10f. Zip Ci   | ode  |  | 10g. Citizen o   | of What Country?  |  |
| 238.0  | alD   | 3646 Horner Place,   | , S.E.   |   |   | 20020  |  | U.S.   | Α.  |  |
| le ma  | Funeral Director                                | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?  |   | <ol> <li>Was Deceder<br/>If Yes, specify</li> </ol>                             | t of Hispanic Origin?<br>Cuban, Mexican, Pu  | (Specify Yes or Netro Rican, etc.)   | o- 14. R<br>B  | lace - American Indiar<br>Ilack, White, etc.  | ٦,   |
| r nearin and wental hygenes<br>item 27 is marked other than "neture!", or items 23s or 28s-f ehow<br>other traumatic event, the Moulcal Examinar most be notified at | þ   | 1 X Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1 □ Yes 2 💥<br>If Yes, Give<br>Year or Dates:  | No  | 1□Yes 2≹  | No Specify:  |  | Spec   | city: Black   |  |
| netur  | sted  | 15. Decedent's Ed<br>(Specify only highest grad  | lucation<br>de completed)  | (0  | ecedent's Usual (   | done during most of v  | working  |  | Business/Industry   |  |
| a Me   | Completed                                       | Elementary/Secondary (0-12)  | College (1-4or   | 5+) /ii   | e. DO NOT use   | retired)   |  | N/A  |   |  |
| nyglene.<br>other then   |   | 12th 17. Father's Name (First, Middle, Last)   |  | N/A   |   | 19 Mother's N  | Nam <i>e (First, Middle</i>  | Maidan Sum   | (2,000)   |  |
| n and Mental Hyglene. Is marked other than "raumatic event, It a Me  | Be  | Melvin Edmund Pr   | ido  |   |   |  |  |  | ame)  |  |
| narke  | 5   |  |  | 10h M   | ailing Address /  |  | eline Sto  |  | um State Zin Code)  |  |
| 7 is r   |   | 19a. Informant's Name/Relationship (7) Adrienne Singley-   | "(däüghte:   | r) $3K$   | arpole I  | treet and Number or<br>ane   | E O C  | or, only or row  | in, State, Elp Code)  |  |
| Depertment of Health important: If item 27 eny injury or other tropics.  |   | 20a. Method of Disposition   | Candido  | 20b. Place of Di  | sposition (Name   | York, 12   | Date   | 20c. Location  | n - City or Town, State   | 9  |
| r. if it   |   | 1 ☐ Burial 2 🖔 Cremation 3 ☐   |  |   | alco Cron   | natory 12–   | 07-05  | Doltar.  | illo Mour   | 10-1   |
| ortani<br>Injury   |   | 4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Ligen  |  | Gliesape  |   |  |  | Funera   | ille, Mary<br>al Home, I  | nc.  |
| eny in   |   | 11/0 da (  | Racan  | 10361   |   | h St., N.  |  |  | •   |  |
| 75   |   | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only   | olications that cause  | the death. Do not   | enter the mode of   | of dying, such as card   | liac or respiratory a  | rrest,   | Approxi   | mate<br>Between  |
| sician and burial-transit  | il Examiner                                     | Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | с.   | a consequence of):  |   |  |  |  |   | <u> </u>   |
| sician   | 100   |  | _  | 4 331.334231.33 37  |   |  |  |  |   |  |
| attending phy<br>for use as the  | hysician/Medical                                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 € Unknown  | d.  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown   | of pregnancy<br>2  Fetal death  | 3 □Ectopic preg<br>5 □ Other (spec  |  | -  |  | Date of delivery<br>Month Day   | Year   |
| gned by the attending phy:<br>be detached for use as the   | by Physician/Med                                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  | 1 ⊡Live birth<br>4 □ Pregnant a<br>9 □ Unknown   | of pregnancy<br>2 Fetal death<br>t time of death  | 5 ☐ Other (spec   | fy)  |  |  | Month Day   | of death?  |
| been signed by the attending phy:<br>should be detached for use as the   | by Physician/Med                                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 MUnknown   | 1 ⊡Live birth<br>4 □ Pregnant a<br>9 □ Unknown   | of pregnancy<br>2 Fetal death<br>t time of death  | 5 ☐ Other (spec   | fy)  |  | tobacco use co   | Month Day  ontribute to the cause  3 □ Probably 4   | of death?  |
| as been signed by the attending phy:<br>2 should be detached for use as the  | by Physician/Med                                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 MUnknown   | 1 ⊡Live birth<br>4 □ Pregnant a<br>9 □ Unknown   | of pregnancy<br>2 Fetal death<br>t time of death  | 5 ☐ Other (spec   | fy)  | 1 □  | tobacco use co   | ontribute to the cause  3 Probably  b. Were autopsy finding prior to completion death?  | of death?  |
| as been signed by the attending phy:<br>2 should be detached for use as the  | Completed by Physician/Med                      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions on   | 1 ⊡Live birth<br>4 □ Pregnant a<br>9 □ Unknown   | of pregnancy<br>2 Fetal death<br>t time of death  | 5 ☐ Other (spec   | se given in Part I.  | 24a. Was   | tobacco use co   | Month Day  ontribute to the cause  3 □ Probably 4   | of death?  |
| as been signed by the attending phy:<br>2 should be detached for use as the  | Be Completed by Physician/Med                   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Munknown  Part II. Other significant conditions | 1 Live birth 4 Pregnant a 9 Unknown  ontributing to death b  | of pregnancy<br>2 Fetal death<br>t time of death<br>out not resulting in th   | 5 Other (spec   | se given in Part I.  26. Place of [  | 24a. Was auto perf   | tobacco use co   | ontribute to the cause  3 Probably 4  b. Were autopsy findir prior to completion death?  1 Yes 2 No   | of death?  Unknown  gs available of cause of                                 |
| is cartificate has been signed by the attending phy, director, page 2 should be detached for use as the  | To Be Completed by Physician/Med                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | 1 □ Live birth 4 □ Pregnant a 9 □ Unknown  ontributing to death b  Hospital: 1 □ Inpati  | of pregnancy 2 Fetal death t time of death out not resulting in th  | 5 Other (spec   | 26. Place of E   | 24a. Was auto perfit 12 Yes Death (Check only g Home 5 🗆 Res   | tobacco use co   | ontribute to the cause  3 Probably 4  b. Were autopsy finding prior to completion death?  1 Yes 2 No  Other (Specify) at  | of death?  Unknown  gs available of cause of                                 |
| n.<br>After this certificete has been signed by the attending phy,<br>tuneral difector, page 2 should be detached for use as the                                     | To Be Completed by Physician/Med                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Munknown  Part II. Other significant conditions | 1 Live birth 4 Pregnant a 9 Unknown  ontributing to death b  Hospital: 1 Inpati 28a. Date of Inju (Month, Da   | of pregnancy 2   Fetal death t time of death  out not resulting in the  | e underlying cau  | se given in Part I.  26. Place of [  | 24a. Was auto perfit 12 Yes Death (Check only g Home 5 🗆 Res   | tobacco use co   | ontribute to the cause  3 Probably 4  b. Were autopsy finding prior to completion death?  1 Yes 2 No  Other (Specify) at  | of death?  Unknown  gs available of cause of  Scene                          |
| n.<br>After this certificete has been signed by the attending phy,<br>tuneral difector, page 2 should be detached for use as the                                     | To Be Completed by Physician/Med                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Hospital: 1   Inpati  28a. Date of Inp.  11/20/2  28e. Ptace of In   | of pregnancy 2 Fetal death t time of death  out not resulting in the ent 2 ER/Outpa  iny y Year) 1243 jury - At home, fam tc. (Specify) | titient 3 DOA e of ry street, factory, c  | 26. Place of Cother: 4 \( \text{Nursing Nursing at Work?} \)                         | 24a. Was auto perfusion of the control of the contr | tobacco use co   | ontribute to the cause  3 Probably 4  b. Were autopsy finding prior to completion death?  1 Yes 2 No  Other (Specify) at  | of death?  Unknown  Igs available of cause of  SCENE                         |
| n.<br>After this certificete has been signed by the attending phy,<br>tuneral difector, page 2 should be detached for use as the                                     | Certification; To Be Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Hospital:  28a. Date of Inju (Month, Date of Inju ( | ent 2 ER/Outpairly Year)  of my knowledge, dot examination and/of   | titient 3 DOA e of p M street, factory, c eath occurred at                      | 26. Place of Cother: 4 Nursing Work? 1 Yes 2 No                                      | 24a. Was auto perfusion of the control of the contr | tobacco use co   | ontribute to the cause  3 Probably 4  b. Were autopsy finding prior to completion death?  12 Yes 2 No  Other (Specify) at curred subject  | of death?  Unknown  Igs available of cause of   SCENE  STUCK  Jumber,  Diamo |
| n.<br>After this certificete has been signed by the attending phy,<br>tuneral difector, page 2 should be detached for use as the                                     | To Be Completed by Physician/Med                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Hospital:  28a. Date of Inju. (Month, Date of Inju.)  1 / 20/2  28e. Place of Inju.)  ysician: To the best   | ent 2 ER/Outpairly Year)  of my knowledge, dot examination and/of   | titient 3 DOA e of y street, factory, co  | 26. Place of Cother: 4 Nursing Work? 1 Yes 2 No                                      | 24a. Was auto perfusion of the control of the contr | tobacco use co Yes 2 No an psy prmed? 2 No one) dence 6 XC how injury occ  Street and Nur wn, State) Cause(s) and date and place | ontribute to the cause  3 Probably 4  b. Were autopsy findir prior to completion death?  1 Press 2 No  Other (Specify) at surred Subject  makes name 2 E  | of death?  Unknown  Igs available of cause of  SCENE  STUCK  Jumber.  Diamol |
| n.<br>After this certificate has been signed by the attending phy,<br>funeral director, page 2 should be detached for use as the                                     | Certification; To Be Completed by Physician/Med | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   | Hospital:  28a. Date of Inju. (Month, Date of Inju.)  1 / 20/2  28e. Place of Inju.)  ysician: To the best   | ent 2 ER/Outpairly Year)  of my knowledge, dot examination and/of   | titient 3 DOA e of p M street, factory, c eath occurred at ir investigation, in | 26. Place of I Other: 4 \( \text{Nursing} \) Injury at Work? 1 \( \text{Yes} \) 2 No | 24a. Was auto perfusion of the courred at the time.  | tobacco use co   | ontribute to the cause  3 Probably 4  b. Were autopsy findir prior to completion death?  1 Yes 2 No  Other (Specify) at curred Subject  maner or Rural Route No  maner as stated. e, and due to the cause | of death?  Unknown  Igs available of cause of   SCENE  STUCK  Jumber,  Diamo |

DHMH 17 Rev 1/2001

William H.

| 1                          | •  |                     | For State Registrer   | State of Maryla   |  | artment of rtificate of   |  |  | giene () () (                              | 5 42378   |
|----------------------------|--|---------------------|---|---|--|---|--|--|--|---|
|                            | Physici<br>/Medi   |                     | 1. Decedent's Name (First, Middle, L<br>SHEILA  |   |  |   | ARIS                                       | 2. Date of Dea<br>Month<br>DELEME          | Day Y                                      |   |
|                            | Examir<br>Funeral<br>Director  | er                  | 578-80-7036   | PKINS HOSP  | FAL<br>s. last birthday)<br>Yrs.         | BALL  If Under 1 Year  Months Days  |  | C/+V                                       | 4c. County of 1959 9 4c, Year, 24, W       | Death  Birthplace (State or Foreign Country)  ashington, D. C.                                |
|                            | e Maryland<br>ta-f show  | ctor                | Usual Residence of Decedent  10a. State 10b. County  Maryland Prince  |   | City, Town or Lo                         |   |  |  |  | 10d. Inside City Limits 1 X Yes 2 □ No  |
|                            | with the   | i Dire              | 10e. Street and Number  1403 Alberta Di   | rive  |  | 10f. Zip Code <b>207</b>  | 47   |  | 10g. Citizen of What                       | ,   |
| 980                        | a within 72 hours after death with the Maryland<br>Jione.<br>I than "natural", or items 23a or 28a-f show<br>II.a M. dical Exemirer must be naillied at  | by Funeral Director | 11. Marital Status  1 🕱 Never Married 2 C Married 3 Widowed 4 Divorced  | 12. Was Decedent Ever in Ammed Forces? 1  No If Yes, Give Year or Dates:  |  |   | Hispanic Origin? (S<br>ban, Mexican, Puer  | Specify Yes or No-<br>to Rican, etc.)      | 14. Race -<br>Black,                       | American Indian, White, etc. Black  |
| 21215-0036                 | within 72 ho<br>ene.<br>than "natur<br>to Medical  | Completed           | 15. Decedent's I<br>(Specify only highest g   | Education<br>rade completed)<br>College (1-4or 5+)  | (Give                                    | dent's Usual Occu<br>kind of work done<br>DO NOT use retire                     | a during most of wo<br>ad)                 |  | 16b. Kind of Busin                         |   |
| Maryland 2                 | be filed<br>tal Hyg<br>d othe  | To Be Co            | 12th grade  17. Father's Name (First, Middle, Lass  Leroy Polla   |   | USII                                     | er/Accen  |  | me (First, Middle,                         | Maiden Surname) nce                        | tion Hall   |
| Baltimore, Mar             | permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marke any injury or other traumatic other.  |                     | LaVonnie Mance  20a. Method of Disposition  1  Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec   | Pollard (Mother 20b.  | Place of Dispo<br>cometery, cree         | 3 Albert sition (Name of natory or other place ashington . Name and Addr Wesley | Dec.  n Cemeter  ess of Facility  v Chavis | Forestvi<br>13,2005<br>y                   | 11e, Mar<br>20c. Location - Cit<br>Adelphi | yland 20747   |
| 8760,                      | Department of the properties o | Icai Examiner       | 23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. SUB ARA  Due to (or as a conse  C. Due to (or as a conse  Due to (or as a conse  Due to (or as a conse  C. Due to (or as a conse  d. | equence of):  advance of):  advance of): | er the mode of dy   | ing, such as cardia                        | c or respiratory arr                       | rest,                                      | Approximate Interval Between Onset and Death 2 BAUS   |
| P.O. Box 68                | death certifii<br>e attending p<br>ed for use as   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🏋 No 9 ☐ Unknown   | 23c. If yes, outcome of pregr<br>1 □ Live birth 2 □ Fel<br>4 □ Pregnant at time of<br>9 □ Unknown                                       | tal death 3                              | Ectopic pregnand Other (specify)  | су   |  | 23d. Date of Month                         | ,   |
|                            | w requires that the been signed by the should be detached  | by                  | Part II. Other significant conditions   | . 1   | sulting in the u                         | nderlying cause g   | ven in Part I.                             |  |  | ute to the cause of death?  |
| Division of Vital Records, | The law<br>ate has b<br>page 2 s   | Completed           | DABETES   | MELLITUS  |  |   |  | 24a. Was a<br>autops<br>perform<br>1XX Yes | med? dea                                   | re autopsy findings available<br>ir to completion of cause of<br>th?<br>Yes 2 \( \text{No} \) |
| Z X                        | Physician: Th<br>this certificate<br>ral director, pag   | To Be               | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No   | Hospital: 1 Inpatient 2   | ☐ ER/Outpatier                           | it 3□ DOA Ot  | hor  | ath <i>Check only or</i>                   | ne)<br>ence 6 □Other(                      | (Specify)   |
| sion of                    | ding<br>After<br>fune  |                     | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time o<br>Injury                    | 28c. Inju   |  |  | ow injury occurred                         | (3,500)   |
| Divis                      | or At  | Certification:      | 3 Suicide 6 Could not determine   | building, etc. (Spec  | eify)                                    |   |  | City or Town                               | n, State)                                  | or Rural Route Number,  |
|                            | the Hospital<br>thin 24 hours a<br>the Funeral I<br>mpletely filled  | edicai              | 29a. Certifier 1 X Certifying F (Check only one) 2 Medical Exa  | hysician: To the best of my kr<br>miner: On the basis of examin<br>and manner stated.   | nowledge, deat<br>nation and/or in       | n occurred at the t<br>vestigation, in my                                       | ime, date and place<br>opinion, death occu | e, and due to the curred at the time, d    | ause(s) and manne<br>ate and place, and    | er as stated.<br>I due to the cause(s)  |
| ı                          | To the To the Comp   | Ň                   | 29b. Signature and title of certifier.  | Q   |  | 1   | se number                                  |  | 9d. Date signed (A                         | 1   |
| 1                          |  |                     | 30. Name and address of person who  | completed cause of death (Ite   |  | Print)  | 5-00                                       |  | 12/0                                       | +105  |
|                            |  |                     | 1 11 1 1 1 1  | ESCU 600  |  | YOUTE   | ST BA                                      | HIMORE                                     | MD,  | 21287   |
|                            | Sta<br>Registi   |                     | 31. Date filed (Month, Day, Year)  DEC 1 2 200  | 2. Registrar's Sign   | nature /                                 | 000   |  |  |  |   |

|  |                  | 1 - For<br>State<br>Registrar  | State of N  | Maryland / Depa<br>Cei                          | artment of Hortificate of L                                       |                     |                                      | ene<br>g. No. 2005             | 42379  |
|--|------------------|--|---|---|---|---------------------|--------------------------------------|--------------------------------|--|
| Phys   | iciar<br>dica    | Decedent's Name (First, Middle     Jesse Hamil                                       |   | out   |   |                     | 2. Date of Death                     | 8 2005°                        | 3. Time of Death 10:51 P M                         |
|  | ninei            | 4a. Facility Name (If not institution Southern Mary                                  |   |   |   | Location of Death   |                                      | 4c. County of Deat             |  |
| Funer  |                  | 5. Social Security Number  |   | Age (In yrs. last birthday)                     | Clinton,  If Under 1 Year  Months Days                            |                     | 8. Date of Birth                     | Pr Geo Co                      | thplace (State or Foreign ountry)                  |
| Direct   |                  | 579-14-9922 Usual Residence of Decedent  |   | 00  |   |                     | 2-14-191                             | .9 MD                          |  |
| Manylar<br>f ahow  | į                | 10a. State 10b. County  MD Pr Ge   | o Co  | 10c. City, Town or Lo                           | cation  |                     |                                      |                                | 10d. Inside City Limits 1 ☐ Yes 2X No              |
| DENLIMOTE, IMETYIGHE A LATE 19-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itame 23a or 28a-f ahow any injury or other traumatic aword, ITE Medical Exactional Juan Lean Cilling 1.   | Euneral Director | 10e. Street and Number 9323 Pella Pla  |   |   | 10f. Zip Code 2073  | 5                   |                                      | g. Citizen of What Co          | ountry?  |
| r death  | araci            | 11. Marital Status   | 12. Was Decede<br>Armed Force                       | nt Ever in U.S. 13.1                            | Was Decedent of Hill<br>If Yes, specify Cubar                     |                     |                                      | 14. Race - Ame<br>Black, Whit  |  |
| ours afte  | i A              | 3 ☐ Widowed 4 ☐ Divorced   | ied MXYes 2<br>If Yes, Give<br>Year or Date         | 1941 -  | 1 ☐ Yes <b>X</b> No   | Specify:            |                                      | Specify: Bla                   | ack  |
| L I 3-U<br>hin 72 hk<br>in "natu<br>Madical  | Completed        | 15. Deceden (Specify only highe: Elementary/Secondary (0-12)                         | t's Education<br>st grade completed)  College (1-4) | (Give   | dent's Usual Occupa<br>kind of work done a<br>DO NOT use retired, | luring most of work |                                      | 6b. Kind of Business/          | Industry   |
| iled with  | 2                | 12th 17. Father's Name (First, Middle,   |   |   | tal Lette   |                     | e (First, Middle, M                  | Govt                           |  |
| latte  | a c              |  |   |   |   | Susie               | Morsell                              | andon damano,                  |  |
| d 2 shouth and half hand half hand half hand half hand trauma  | 9                | 19a. Informant's Name/Relations Frances Prout  |   |   | ng Address <i>(Street a</i><br>P <b>ella Pla</b>                  |                     | •                                    | City or Town, State, 2         | ?ip Code)  |
| or Heall   |                  | 20a. Method of Disposition 1 □ Burial 2 □ Cremation                                  |   | 20b. Place of Dispo                             |   |                     |                                      | 0c. Location - City or         | Town, State  |
| mit. Pages<br>pertment of<br>portant: If it  |                  | 4 □ Donation 5 □ Other (S  | (pecify)  | Md. Natl  | Memorial  Name and Addres   |                     | /17/05 L                             | aurel, MO                      | 20703  |
|  | one              | > Suddlet  | YSINSON   |   |   |                     |                                      | l Home, P.<br>Hills, MD        |  |
| Dhysisis   |                  | 23a. Party Enter the disease of shook, or heart failure. List Immediate Cause (Final | complications that cau-<br>only one cause on each   | h line.   |   |                     |                                      | st,                            | Approximate<br>Interval Between<br>Onset and Death |
| Physicia<br>/Medic<br>Examin   | al               | disease or condition resulting in death)   | . `   | A C A R D as a consequence of):                 |   |                     |                                      |                                |  |
| 1  |                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | b. ATA  | ERUSCLE/<br>as a consequence of):               | rotic (   | CARDIN              | VAS CULA                             | on Diseas                      | <b>3</b>   |
| xecuted<br>end<br>Il-transit   | - unex           | Cause (Disease or injury that initiated events resulting in death) Last              | c. Hyj  | PERTENSICE as a consequence of):                | E CARD  | COVAS CO            | ear Di                               | SEASE                          |  |
| d / bU,<br>cate be executed<br>physicien end<br>the burial-transit   | I cold           |  | d   |   |   |                     |                                      |                                |  |
| Geath certific:  | Model of         | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome                                |   |   |                     |                                      | 23d. Date of del               | livery   |
| CORGS, P.O. BOX of wrequires thet the death certification is greatly the ettending should be detached for use as   | ololes.          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                              |   | t at time of death 5                            | □Ectopic pregnancy<br>□ Other (specify)                           |                     |                                      | Month                          | Day Year   |
| ords, F. requires thet the een signed by nould be detact   | Day d            | Part II. Other significant conditi   | ons contributing to deat                            | h but not resulting in the u                    | nderlying cause give  | en in Part I.       |                                      | acco use contribute to         |  |
| KECOFG he taw requir he tax been si age 2 should I   | 000              |  |   |   |   |                     | 1 ∐ Yes<br>24a. Was an               |                                | robably 4 ☐Unknown                                 |
| F = %  | 9                |  |   |   |   |                     | autopsy<br>perform<br>1 Tes 2        | ed?   death?                   | utopsy findings available completion of cause of   |
| OT VICAL ME Physician: The it this certificate ha ral director, page 2   | 9                | 25. Was case referred to medica examiner?  | Hospital: 1 ☐ Inp                                   | atient 2 NER/Outpatier                          | Othe  | 20                  | th (Check only one                   | nce 6 Other (Spe               | -14.0  |
|  | Ė                |  | 28a. Date of (Month,                                |   | f 28c. Injury<br>Work   | at c?               | 28d. Describe how                    |                                | Unity)   |
| VISI<br>Atter<br>r dea<br>ector<br>by the  | 19100            | 2 ☐ Accident investi<br>3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ                 | not be 28e. Place of                                | tnjury - At home, farm, str<br>, etc. (Specify) |   | Yes 2 □No           | 28f. Location (Stre<br>City or Town, | eet and Number or Ru<br>State) | ural Route Number,                                 |
| Hospital or Attended to the safe of the sa | 3                |  |   | est of my knowledge, deat                       | h occurred at the tim   | ne date and place   |                                      |                                | stated   |
| To the Hospital within 24 hours a To the Funeral Completely filled   |                  | (Check only 2 Medical one)   | Examiner: On the basi<br>and manner                 | s of examination and/or in                      | vestigation, in my or   | pinion, death occur | red at the time, dat                 | te and place, and due          | e to the cause(s)                                  |
| To Te Eoo  |                  | 29b. Signature and title of certifie   | 5 11.   |   | 29c. License  | 5986                |                                      | d. Date signed (Mont           |  |
| (3)  |                  | 30. Name and address of person   | who completed cause                                 | of death (Item 23a) (Type,                      |   | 0 10 6              |                                      |                                | _ ~ ~ ~  |
|  | State            | Victor E. Herr 31. Date filed (Month, Day, Year,                                     | 2 Ren   | istrar's Signature                              |   | rt Washir           | igton, MD                            | 20744                          |  |
|  | istra            |  | 005   | JA Sin  |   |                     |                                      |                                |  |

|                            |   |                  | For State   | State of Ma  | ryland / l       | Department o<br>Certificate o                      |  |                            | 2000                      | 42380   |
|----------------------------|---|------------------|---|--|------------------|--|--|----------------------------|---------------------------|---|
|                            |   |                  | Registrar  1. Decedent's Name (First, Middle, Lass  | t)   |                  | Certificate  | Di Dealli                                    | 2. Date of Deat            | e <b>g. No.</b><br>h      | 3. Time of Death  |
|                            | Physici   |                  | Cloris  | L.   |                  | Pyles  |  | December 7                 | 7. 2005 Ye                | 4:00 P M  |
| >                          | /Medic<br>Examir  |                  | 4a. Facility Name (If not institution, give   | street and number)                                     |                  |  | m, or Location of Dea                        |                            | 4c. County of E           |   |
|                            |   |                  | 3601 Barry Drive  |  |                  |  | Hills  |                            |                           | George's  |
|                            | Funeral   |                  | Social Security Number     6. Se  | 7. Age   | (In yrs. last bi | rthday) If Under 1 Y<br>Yrs. Months Da             | ear If Under 24 Hrs<br>ays Hours Min         | . (Month, Day,             | Year) 9.                  | Birthplace (State or Foreign Country)                     |
|                            | Director  |                  | 219-48-4034<br>Usual Residence of Decedent  | AAA  | 94               | 113.   |  | December                   | 1, 1911                   | Iowa  |
|                            | yland<br>yland  |                  | 10a. State 10b. County  |  | 10c. City, Tow   | m or Location                                      |  |                            |                           | 10d. Inside City Limits                                   |
|                            | a-fsh   | cto              | Maryland Prince G   | eorge's  | Templ            | e Hills  |  |                            |                           | 1 ☐ Yes 2√XNo   |
|                            | or 28   | Oire             | 10e. Street and Number  |  |                  | 10f. Zip Co<br>2074                                |  | 1                          | 0g. Citizen of Wha<br>USA | t Country?  |
|                            | within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or tlems 23e or 28a-f show<br>the Medical Examinat must be rodified at   | Funeral Director | 3601 Barry Drive  | 10 Was Davidson 5                                      |                  |  |  | Pagaiby Van as Na          |                           | American Indian,  |
|                            | Item<br>Item  | in.              | 11. Marital Status  1 ☐ Never Married 2 ☐ Married   | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No  |                  | If Yes, specify                                    | of Hispanic Origin? (<br>Cuban, Mexican, Pue | rto Rican, etc.)           |                           | White, etc.   |
| 920                        | urs af  | þ                | 3/XWidowed 4 □ Divorced   | If Yes, Give<br>Year or Dates:                         |                  | 1 □ Yes 2,□  | No Specify:                                  |                            | Specify:                  | White   |
| 21215-0036                 | 72 ho   | Completed        | 15. Decedent's Ed<br>(Specify only highest grad   |  | 16a              | . Decedent's Usual O                               | ccupation<br>one during most of wo           | orkina                     | 16b. Kind of Busin        | ess/Industry  |
| 2                          | ithin Je.   | mple             | Elementary/Secondary (0-12)   | College (1-4or 5+                                      | -)               | life. DO NOT use re                                | etired)                                      |                            | _                         |   |
|                            | iled w<br>Hygiei<br>ther ti   |                  | 17. Father's Name (First, Middle, Last)   |  |                  | Ho   | memaker<br>18. Mother's Na                   | me (First, Middle, M       | In Home                   |   |
| auc                        | d be l  | To Be            | Arthur Ludwig   |  |                  |  |  | lla Wise                   | ,                         |   |
| Maryland                   | shoul<br>nd Ma<br>marl  | -                | 19a. Informant's Name/Relationship (7   | ype, Print)  | 198              | o. Mailing Address (St                             | reet and Number or R                         | iural Route Number         | City or Town, Sta         | te, Zip Code)   |
|                            | and 2<br>alth a<br>1 27 is  |                  | Richard W. Pyles / Son  | n  |                  | '06 Spring Te                                      |  | Hills, Mar                 | yland 207                 | 748   |
| ore                        | of He of Herr   |                  | 20a. Method of Disposition  1 X Burial 2 Cremation 3  | Removal from State                                     | 20b. Place o     | of Disposition (Name of<br>ery, crematory or other | place)                                       | Date                       | 20c. Location - City      | or Town, State  |
| altimore,                  | Pag<br>ment<br>tent: I  |                  | * 4 □ Donation 5 □ Other (Specify   | )  | St. Bar          | nabas Church                                       |  | /2005                      | Temple Hil                | lls, Maryland   |
| Ball                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel; or items 23e or 28a-f show emy injury or other treumetic event, the Medical Examiner must be notified at once. |                  | 21. Signature i Funeral Service Licent  | 300  |                  | 22. Name and A 6160 Oxor                           | ddress of Facility<br>Ge<br>1 Hill Road C    | orge P. Kal<br>xon Hill, M | as Funeral<br>arvland     | Home PA<br>20745  |
| П                          |   |                  | 23a. Part 1. Enter the disease, or compositions, or heart failure. List only  | lications that caused tone cause on each line          | the death. Do    |  |  |                            |                           | Approximate<br>Interval Between                           |
| k                          | Physician   | 0                | Immediate Cause (Final disease or condition   |  |                  | : CARDIOVASCI                                      | TAR DISTAGE                                  |                            |                           | Onset and Death  Vears                                    |
|                            | /Medical<br>Examiner  |                  | resulting in death)   | Due to (or as a  |                  |  |  |                            |                           |   |
|                            |   | 10               | Sequentially list conditions,   | b. Due to (or as a                                     | consequence      | of):   |  |                            |                           |   |
|                            | uted<br>d<br>ansit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | _  |                  |  |  |                            |                           |   |
| o,                         | an and<br>rial-tra  |                  | resulting in death) Last  | Due to (or as a  | consequence      | of):   |  |                            |                           |   |
| 68760,                     | ficate be executed<br>physician and<br>as the burial-transit  | edlcal           | (   | d  |                  |  |  |                            |                           |   |
|                            |   |                  | IF FEMALE:  | 22a If you outcome                                     | of prognancy     |  |  |                            |                           |   |
| Вох                        | death certifi<br>le attending<br>ed for use as  | Physiclan/M      | in the past 12 months?  | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t | 2 Fetal death    | 3 ☐Ectopic pregn<br>5 ☐ Other (specif              |  |                            | 23d. Date of<br>Month     | Day Year  |
| o.                         | 0 0   | ysic             | 1 ☐ Yes 2 🔀 No<br>9 ☐ Unknown   | 9☐ Unknown   |                  |  | //   |                            |                           |   |
| <u>α</u>                   | The law requires that the ste has been signed by th bage 2 should be detache  | by Pł            | Part II. Other significant conditions of  | ontributing to death bu                                | t not resulting  | in the underlying caus                             | e given in Part I.                           | 23e. Did tob               | pacco use contribut       | te to the cause of death?                                 |
| rds                        | w require<br>been sig<br>should b   |                  |   |  |                  |  |  | 1 □ Ye                     | as 2 <b>X</b> ∑No 3 [     | Probably 4 Unknown  |
| 000                        | e taw re<br>has bed<br>je 2 sho   | Completed        |   |  |                  |  |  | 24a. Was a                 |                           | e autopsy findings available<br>to completion of cause of |
| Ä                          |   | Com              |   |  |                  |  |  | perform                    | ned? deat                 | h?<br>Yes 2□ No   |
| /ita                       | ysicien: Th<br>is certificate<br>director, pag  | Be               | 25. Was case referred to medical examiner?  | Lie es itali   |                  |  | 0.1  | eath (Check only on        |                           |   |
| of                         | S S   | - To             | 1 ☐ Yes 2 🗓 🗓 o   | Hospital: 1 Inpatier 28a. Date of Injury               |                  | utpatient 3 □ DOA Time of 28c.                     |  | Home 5 Reside              | ence 6 Other (            | Specify)  |
| uo                         | ding<br>h.<br>After<br>funer  | tion             | 1XXNatural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day  |                  | Injury M   | Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No         | 20d. Doscribo no           | m injury cocurred         |   |
| Division of Vital Records, | Attending Physicien: r death. ector: After this certification of the funeral director.  | ifica            | 3 Suicide 6 Could not be  | 28e. Place of Inju                                     | ry - At home, f  | arm, street, factory, of                           | fice   | 28f. Location (St.         | reet and Number o         | r Rural Route Number,                                     |
| Ö                          | s afte  | Certification:   | 4 Homicide  | building, etc.   | . (Зреспу)       |  |  | City or Town               | i, State)                 |   |
|                            | To the Hospitel or Attending Ph within 24 hours after death.  To the Funerel Director: After th completely filled in by the funeral   | edical           | (Check only 2 Medical Exam  | ysicien: To the best on the basis of                   | examination as   |  |  |                            |                           |   |
|                            | To the P<br>within 24<br>To the F<br>complete   | Med              | one)  | and manner stat  | ed.              |  | cense number                                 |                            | 9d. Date signed (M        |   |
|                            | T wit   |                  | 29b. Signature and title of certifier   | 11   |                  | 250.   | D19  |                            |                           | er 8, 2005  |
| ^                          | (10)  |                  | 30. Name and address of person who  | completed cause of de                                  | ath (Item 23a)   | (Type, Print)                                      |  |                            |                           |   |
| 2                          | (10)  |                  | Frank M. Ryan MD  |  | ngston Ro        | oad #103 Ft  | . Washington                                 | , Maryland                 | 20744                     |   |
|                            |   | atė              | 31. Date filed (Month, Day, Year)   | 32. Registra   | r's Signature    | Care.  |  |                            |                           |   |
|                            | Regist  | rar              | DEC 1 3 2005  | Bleese   | A K              |  |  |                            |                           |   |

State of Maryland / Department of Health and Mental Hygiene) For state 12-19-05 Registrar Amend#23a.Prt.1.Per Phys.PGC cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 10, **Physician** CHARLES III PAYNE 2005 17:05 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGE 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of 8 Irth (Month, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) | North, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 223-26-9774 WASHINGTON, DC Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "natural", or Iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 XYes 2 No PRINCE GEORGE Directo FT. WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8932 BLUFFWOOD LANE U.S.A.Funerai 20744 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 GYes 2 No ARMY If Yes, Give ARMY Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4yrs Elementary/Secondary (0-12) ASSISTANT CONTROLLER PRIVATE permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygie.
Importent: if Item 27 is marked other th
eny injury or other traumatic event, III.a. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES B. PAYNE JR RUTH BURFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM MASON/NEPHEW 1613 IDIEWOOD AVENUE RICHMOND, VA 23220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12-19-2005 CHELTENHAM, MD 4 □ Donation 5 □ Other (Specify) MD VETERANS CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillium. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) with Repeatory Physician Bronchopneumonia /Medical onsequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 →No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 € No 1 Yes 2⊞No To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated & certifier 29b. Signature ag 29c. License number 29d. Date signed (Month, Day, Year) D0055121 Dec 12 2005 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)
Richard Falmer MD B28 Southern Avenue SE Juite 310 Worshing has DC 20032 31. Date filed (Month, Day, Year) State BEC 1 4 2005 Registrar

|   |  |                  | riease  | Chata of Manufac  |                                  |   |                                |                                   | •  | •  |  |
|---|--|------------------|---|---|----------------------------------|---|--------------------------------|-----------------------------------|--|--|--|
|   |  |                  | For State   | State of Marylan  |                                  | artment of F<br>rtificate of                                  |                                | na Menta                          |  | CUUD                                     | 42382  |
|   |  |                  | Registrar     Decedent's Name (First, Middle, La  | st)   | Cei                              | lilicate of   | Dealli                         | 2 Da                              | Reg. I<br>te of Death                                    | Nó.                                      | 3. Time of Death                                 |
|   | ysicia   |                  | HENRY ALLEN PAR   |   |                                  |   |                                | Mo                                | onth (   | Day Year                                 | 11 00 M  |
|   | Medic<br>camin                                   |                  | 4a. Facility Name (If not institution, giv  |   |                                  | 4b. City, Town, o   | r Location of                  |                                   |  | 9, 2005<br>4c. County of Dea             |  |
| ^   | .amm   | CI.              | Washington Adve   | ntist Hospital  |                                  | Takoma  | Park                           |                                   |  | Montgome                                 | <b>r</b> 17                                      |
| Fun   | ieral  |                  | 5. Social Security Number 6. 5  | Sex 7. Age (In yrs.   |                                  | If Under 1 Year<br>Months Days                                |                                |                                   | te of Birth<br>onth, Day, Yea                            | 9. Bir                                   | thplace (State or Foreign ountry)                |
| Dire  | ctor   |                  | 579-52-1319   | 65  | Yrs.                             | ,   |                                |                                   | . 20,  |  | rginia   |
| and   | -  |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. Cit  | y, Town or Lo                    | ocation   |                                |                                   |  |  | 10d. Inside City Limits                          |
| Mary<br>-f sho  | pag  | ţ                | Maryland Prince   | Coorgo's Hv   | attsvi.                          | 11e   |                                |                                   |  |  | 1∭Yes 2 ☐ No                                     |
| r 286   | Dott   | lrec             | 10e. Street and Number  | Seolge S  |                                  | 10f. Zip Code   |                                |                                   | 10g.   | Citizen of What C                        | ountry?  |
| ITIC Z I Z I 3-0030  be filed within 72 hours atter death with the Maryland tal Hygiene.  tal Hygiene.  | at be  | Funeral Director | 5805 42nd Avenue  | , Apt. 304  |                                  | 20781   |                                |                                   | U  | .S.A.                                    |  |
| r dea   | BL IS  | Iner             | 11. Marital Status  | 12. Was Decedent Ever in U<br>Armed Forces?   | .S. 13.                          | Was Decedent of H   | lispanic Origi<br>an, Mexican, | in? (Specify Ye<br>Puerto Rican,  | es or No-  | 14. Race - Ame<br>Black, Whi             |  |
| s afte  | ŧ.   | by Fu            | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced  | 1 ☐ Yes 2 📉 No<br>If Yes, Give  |                                  | 1 ☐ Yes 2X No   | Specify:                       |                                   |  | Specify: T.T1                            | nite   |
| hour turel  | E.   | ed b             | 15. Decedent's E  | Year or Dates:  | 16a Dece                         | dent's Usual Occur  | nation                         |                                   | 16b  | WI<br>Kind of Business                   |  |
| 1 72 u  | Andio  | plet             | (Specify only highest gri   | ade completed)  | (Give                            | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most od)                | of working                        |  | rker Plu                                 | '  |
| d with<br>giene   | uke h  | Completed        | Elementary/Secondary (U-12)   | College (1-4or 5+)  | Maste                            | er Plumbe   | r ·                            | -                                 |  | d Heatin                                 |  |
| al Hyger  | vent,  | Bec              | 17. Father's Name (First, Middle, Last  | )   |                                  |   | 18. Mother                     | s Name (First,                    | Middle, Maid   | len Sumame)                              |  |
| Menta   | atic e   | To               | Virgil H. Parker  |   |                                  | _   | Elen                           | or Tho                            | mpson  |  |  |
| 2 sho<br>and<br>Is m  | aum.   |                  | 19a. Informant's Name/Relationship  |   |                                  | ng Address (Street  |                                |                                   |  |  |  |
| and and lealth  | her tı   |                  | Vicky J. Downing  |   | 1616                             | Millston sition (Name of                                      | e Driv                         | re, Edg                           |  |  |  |
| Ges 1   | or ot  |                  | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐   | Removal from State  | emetery, crei                    | natory or other plac  |                                |                                   |  | Location - City or                       |  |
| Defitilitions, Interpretation 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deputrment of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel", or Items 23a or 28e-1 show | njury  |                  | * 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice   |   |                                  | coln Cemete<br>2. Name and Addre                              |                                | 2/13/20                           | 005 Bi   | centwood,                                | Maryland   |
| Dep mod   | any ii   |                  | 21. Signature of Puneral Service Lice   | <b>X</b> .  |                                  | 739 Balt  |                                |                                   |  |  |  |
| H-II-s.   |  |                  | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List only                                 |   |                                  |   |                                |                                   |  | viiic, iii                               | Approximate                                      |
| Physic  | oion   |                  | Immediate Cause (Final  | one cause on each line.   |                                  |   |                                |                                   |  |  | Interval Between<br>Onset and Death              |
| /Med  |  |                  | disease or condition resulting in death)  | aDue toa conseq   | uence of):                       |   |                                | 971                               |  | r.                                       |  |
| Exam  | iner   |                  | Sequentially list conditions  | 6 Chronic   | 000                              | Struct  | ere 1                          | Tulan.                            | mon  | - SISLA                                  | Le   |
| <u> </u>  | ti.  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (o. as a conseq  | uence of):                       |   |                                |                                   |  | 9  |  |
| secute  | -tran  | Examiner         | that initiated events resulting in death) Last  | cDue to (or as a conseq   | uanca of):                       |   |                                |                                   |  |  |  |
| I NECOLUS, F.O. BOX 00/00,  The law requires that the death certificate be executed are has been signed by the attending physician and  | should be detached for use as the burial-transit | calE             |   |   | 23.740 0.7,                      |   |                                |                                   |  |  |  |
| ficate  | s the  |                  |   | _ d.  |                                  |   |                                |                                   |  |  |  |
| n certi   | nse s  | Physician/Medi   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregna  |                                  | ne  |                                |                                   |  | 23d. Date of de                          | livery   |
| death<br>death  | od for   | icia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d<br>9 ☐ Unknown                     |                                  | Ectopic pregnancy Other (specify)                             | <i>'</i>                       |                                   |  | Month                                    | Day Year   |
| at the  | stachi   | hys              | 9 Unknown   |   |                                  |   |                                |                                   |  |  |  |
| res th  | pe q   | by               | Part II. Other significant conditions   | contributing to death but not res   | ulting in the u                  | nderlying cause giv   | en in Part I.                  | 23                                |  |  | o the cause of death?                            |
| v requires to been signer   | hould  | eted             |   |   |                                  |   |                                | _                                 |  |  |  |
| S a C   | N  | Completed        |   |   |                                  |   |                                | 24                                | <ul> <li>a. Was an<br/>autopsy<br/>performed?</li> </ul> | prior to                                 | utopsy findings available completion of cause of |
| n: Th<br>ficate   | funeral director, page 2 s                       | e Co             | OF Man area safessed to the direct  |   | - 1                              |   |                                |                                   | ]Yes 2 🔀 1   | No 1 ☐ Yes                               | 2 □ No   |
| VICAL<br>Sicien:  | irecto   | o Be             | 25. Was case referred to medical examiner?  1 ☐ Yes 2 🗓 No  | Hospital: 1 ☐ Inpatient 2 🛛   | ER/Outpatier                     | oth 3CLDOA Oth  | 0.0                            | of Death (Chec                    |  | 6 ☐Other (Spe                            | av6.1)   |
| P P C   | eralo  | lon; T           | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time o                      |   | y at                           |                                   | escribe how in   |  | cny)   |
| TSION  Witending death. ctor: Afte  | no fun   | atio             | 1 XNatural 5 ☐ Pending<br>2 ☐ Accident investigation  | $n \cap n \cap n$   | Injury                           |   | Yes 2 □ No                     | 0                                 |  |  |  |
| r Atte  | by th  | Certificati      | 3 ☐ Suicide 6 ☐ Could not to determine  | 28e. Pr. of Injury - Al ho<br>by ding, etc. & pecif                                     | ome, farm, str                   | eet, factory, office  |                                | 28f. Loc<br>Cit                   | cation (Street<br>y or Town, St                          | and Number or Rate)                      | ural Route Number,                               |
| urs af  | lled ir  |                  | //  | 11 11   |                                  |   |                                |                                   |  |  |  |
| UIVISION OI VICA Within 24 hours after death.  To the Funerel Director: After this certification to the Funerel Director: After this certification.   | completely filled in by the                      | edical           | 29a. Certifier 1∑ Certifying P<br>(Check only 2☐ Medical Examone)   | nysician: To the best of my kno<br>miner: On the basis of examina<br>and manner stated. | owledge, deat<br>ition and/or in | h occurred at the tir<br>vestigation, in my o                 | ne, date and<br>pinion, death  | place, and due<br>occurred at the | e to the cause<br>to time, date a                        | e(s) and manner as<br>and place, and due | s stated.<br>e to the cause(s)                   |
| o the   | omple  | Med              | 29b. Signature and the of certifier   | and trailler stated.  |                                  | 29c. Licens   | e number                       |                                   | 29d. (   | Date signed (Mont                        | h, Day, Year)                                    |
| ⊢ ≯ F   | ō  |                  | 1-1-  | bon   |                                  | //  | 500                            | 73                                | 1:   | 7/191                                    | 2  |
| 1/19  | )  |                  | 30. Nam no address of person who  | completed cause of death (Item  | n 23a) (Type,                    | Print)  |                                |                                   | 1/6  | 1011                                     | 0 3  |
|   | /  |                  | Stephen Monroe  | Smith, MD 921   | 0 Corp                           | orate Blv   | 7d., St                        | te. 210                           | Rock   | ville, M                                 | D 20850  |
|   | Sta  |                  | 31. Date filed (Month, Day, Year)   | 2. Registrar's Signa  | ature                            | BI  |                                |                                   |  |  |  |
| He  | egistr   | ar               | DEC 1 4 200   | DOMEN SO  | 1                                |   |                                |                                   |  |  |  |

|                     |   |   | 1 - For<br>State<br>Registrar   | State of Maryla  |                                  | artment<br>rtificate         |                         |                            |                           | F                                       | Reg. No.  | 005   | 42383   | 3         |
|---------------------|---|---|---|--|----------------------------------|------------------------------|-------------------------|----------------------------|---------------------------|---|---|---|---|-----------|
| *                   | Physici   | an  | 1. Decedent's Name (First, Middle, Last)  |  |                                  |                              |                         |                            |                           | <ol><li>Date of Dea<br/>Month</li></ol> | ith<br>Day  | Yea   | 3. Time of Death                                    | 1         |
|                     | /Media  |   | FRANCIS JOSEPH PI   |  |                                  |                              |                         |                            |                           | Decembe                                 | -   | 2005  |   | М         |
|                     | Examir  | ier   | 4a. Facility Name (If not institution, give s  Doctor's Communit                        |  |                                  | 4b. City,                    |                         | Location o                 | f Death                   |   |   | County of De                                | ath<br>George's                                     |           |
| 100                 |   |   | 5. Social Security Number 6. Sex  | -  | (ast birthday)                   | If Under                     |                         | If Under 2                 | 24 Hrs.                   | 8. Date of Birtl                        |   |   |   | ian       |
| seedy.              | Funeral<br>Director   |   |   | M 2□F 82   | Yrs.                             | Months                       | Days                    | Hours                      | Min.                      | (Month, Day<br>Oct. 8.                  | r, Year)  |   | irthplace (State or Fore<br>Country)<br>Shington, I |           |
|                     | yland   |   | 10a. State 10b. County  | 10c. C   | ity, Town or Lo                  | ocation                      |                         |                            |                           |   |   |   | 10d. Inside City Lim                                | its       |
|                     | a-f s   | ctor  | Maryland Prince Ge  | orge's Gr  | eenbe11                          | t                            |                         |                            |                           |   |   |   | 1∭Yes 2□I   | Vo        |
|                     | or 28   | Oire  | 10e. Street and Number  | J  |                                  | 10f. Zip                     | Code                    |                            |                           |   | 10g. Citiz  | en of What (                                | Country?  |           |
|                     | ath w   | rai   | 8 Parkway, Apt. 2   |  |                                  |                              | 770                     |                            |                           |   | U.S.  |   |   |           |
|                     | er de<br>İtemi  | Funeral Director  |   | 12. Was Decedent Ever in I<br>Armed Forces?  | J.S. 13.                         | Was Deced<br>If Yes, spec    | ent of His<br>ify Cubar | panic Orig<br>n, Mexican   | gin? (Spec<br>, Puerto P  | cify Yes or No-<br>lican, etc.)         | 1   | <ol> <li>Hace - An<br/>Black, Wh</li> </ol> | nerican Indian,<br>iite, etc.                       |           |
| 36                  | irs aff   | by F  | 1   Never Married 2 Married  3   Widowed 4 Divorced                                     | 1 X Yes 2 □ No<br>If Yes, Give<br>Year or Dates: WWI   |                                  | 1 ☐ Yes 2                    | 2 <b>∑</b> No           | Specify:                   |                           |   | ,   | Specify: Ta                                 | hite  |           |
| 9                   | be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or items 23e or 28e-f show event. I're Medical Exam ear medical inclined at   | ted   | 15. Decedent's Edu  | cation   | 16a. Dece                        | dent's Usua                  | Occupa                  | tion                       |                           |   | 16b. Kin  | d of Busines                                |   |           |
| 215                 | within 7<br>ene.<br>than "n   | pje   | (Specify only highest grade<br>Elementary/Secondary (0-12)                              | College (1-4or 5+)   | (Give                            | kind of wor<br>DO NOT us     | k done di<br>e retired) | uring most                 | of workin                 | 9                                       | Unit  | ed St                                       | ates  |           |
| 2                   | filed within Hygiene. wither than out, the Man  | Completed   | 12  |  | Supe                             | rviso                        |                         |                            |                           |   |   | offi:                                       | ce  |           |
| nd                  | ntal Hy   | Be  | 17. Father's Name (First, Middle, Last)   |  |                                  |                              |                         | 18. Mothe                  | r's Name                  | (First, Middle,                         | Maiden S  | Surname)                                    |   |           |
| yla                 | should be<br>nd Mental<br>marked o  | 은   | Erich Planer  | D. A.  | 401 44 11                        |                              | /2:                     |                            |                           | ilbane                                  |   |   |   |           |
| Maryland 21215-0036 | d 2 a |   | 19a. Informant's Name/Relationship (Ty  |  |                                  |                              |                         |                            |                           | Route Numbe                             |   |   |   |           |
|                     | 1 an<br>Heal<br>em 2<br>ther  |   | Patricia M. Cavana  20a. Method of Disposition  | 20b.   | Place of Dispo                   | sition (Nam                  | e of                    |                            |                           | Mary                                    |   |   | or Town, State                                      | _         |
| JO.                 | 0 0   |   | 1 Burial 2 □ Cremation 3 □R 4 □ Donation 5 □ Other (Specify)                            |  | cemetery, crei<br>rt Linco       |                              |                         |                            | 12/10                     | 1/2005                                  |   | -   | Maryland  |           |
| Baltimore,          | 글론발금  | 1   | 21. Signature of Funeral Service License  |  |                                  |                              | -                       | -                          |                           | h's Fur                                 |   |   |   | _         |
| ã                   | Dep<br>Imp  | ļ.  | It forstance  | Haseh  | 1                                |                              |                         |                            |                           |   |   |   | MD 20781  |           |
|                     | Physician<br>/Medical<br>Examiner   | Due to (or as a consequence of):  CONGESTIVE HEART FAILURE EXACERBATION |   |  |                                  |                              |                         |                            |                           |   | Approximate Interval Between Onset and Death  3 Weeks |   |   |           |
| 68760,              | The law requires that the death certificate be executed the sace been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | edicai Examiner   | Cause (Disease or injury that initiated events resulting in death) Last                 | Due to (or as a conse  |                                  |                              |                         |                            |                           |   |   |   |   |           |
| .O. Box             | at the death certific<br>by the attending pi<br>tached for use as f   | Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | al death 3[                      | ∃Ectopic pre<br>∃ Other (spe |                         |                            |                           |   | 23  | 3d. Date of d<br>Month                      | elivery<br>Day Year                                 |           |
| rds, P              | w requires that<br>been signed t<br>should be det   |   | Part II. Other significant conditions con  Advanced                                     | tributing to death but not re  | sulting in the u                 | nderlying ca                 | iuse give               | n in Part I.               |                           |   | bacco us<br>es 2 €                                    | 1   | to the cause of death?<br>Probably 4 Dunknow        | WΠ        |
| Vital Records,      |   | Completed by  |   |  |                                  |                              |                         |                            |                           | 24a. Was a autop: perfor                | sy  | 24b. Were a prior to death?                 |   | ole<br>of |
| Vita                | Physician: The this certificate ral director, pag   | Be  | 25. Was case referred to medical examiner?  | ospital:   |                                  |                              | - Ch-                   |                            | of Death                  | Check only or                           | ne  |   |   |           |
| of                  | Phys<br>this<br>al dir  | 2   | 1 Yes 2 No  | 28a. Date of Injury  | ER/Outpatier                     |                              |                         | 4 🗆 1401                   |                           | e 5 Resid                               |   |   | ecify)  |           |
| U                   | ding l<br>h.<br>After<br>funer  | ton   | 1 ☑Natural 5 ☐ Pending  | (Month, Day Year)  | Injury                           | M                            | Bc. Injury<br>Work      | at<br>?<br>es 2□N          |                           | 3d. Describe h                          | ow injury   | occurred                                    |   |           |
| Division            | tend<br>death<br>tor:<br>the  | Certification:  | 2 Accident investigation 3 Suicide 6 Could not be determined                            | 28e. Place of Injury - At the building, etc. (Spec   | nome, farm, str<br>ify)          |                              |                         |                            |                           | 3f. Location (S<br>City or Tow          | treet and<br>n, State)                                | Number or F                                 | Rural Route Number,                                 |           |
|                     | Hospita<br>24 hours<br>Funeral  | edical C  | 29a. Certifier 1 Certifying Physical (Check only one) 2 Madical Examination             | lician: To the best of my kn<br>ner: On the basis of examin<br>and manner stated.                | owledge, deat<br>ation and/or in | h occurred a<br>vestigation, | at the time<br>in my op | e, date and<br>inion, deat | d place, ar<br>th occurre | nd due to the d<br>d at the time, d     | ause(s) a<br>late and p                               | ind manner a<br>place, and du               | as stated.<br>ue to the cause(s)                    |           |
| •                   | within To the comple  | M   | 29b. Signature and title of certifier   | unaliemo   | MD                               | 29c.                         | License                 | number 5 8                 | 21                        | 3                                       | / 2   | signed (Mor                                 | nth, Day, Year)                                     |           |
| )_                  | (5) 1Va   |   | 30. Name and address of person who co   | mpleted cause of death (Ite  | m 23a) (Туре,<br><b>5 Н</b> Ш    | Print)<br>10 VEX             | PK                      | wy                         | Grea                      | 3 enbect                                | + M.  | D 20  | 770   |           |
|                     | Sta<br>Registr  |   | 31. Date filed (Month, Day, Year)  DEC 1 4 2005   | 32. Registrar's Sign   | ature                            | E                            |                         |                            |                           |   |   |   |   |           |

DHMH 17 Rev 1/2001

FRANCIS JUSEPH PLANER

|           |   |                               | For<br>State<br>Registrar   | State of M                                     | aryland / [                       | Оера                   |                           | of H                   | ealth a                    | and M                   | _                               |                               | 05                             | 42384   |
|-----------|---|-------------------------------|---|--|-----------------------------------|------------------------|---------------------------|------------------------|----------------------------|-------------------------|---------------------------------|-------------------------------|--------------------------------|---|
| 35        | 8 . W 3   | er .                          | 1. Decedent's Name (First, Middle, La   | ast)   |                                   |                        |                           |                        |                            |                         | 2. Date of De<br>Month          | ath<br>Day                    | Year                           | 3. Time of Death                                |
| F         | Physici<br>/Medio   |                               | LEONA CHRISTIN  | E PERCY  |                                   |                        |                           |                        |                            |                         | Decemb                          |                               |                                | 5:40 a™   |
|           | Examir  |                               | 4a. Facility Name (If not institution, gire   | ve street and number)                          |                                   |                        | 4b. City, 1               | Town, or               | Location of                | of Death                |                                 | 4c. Cou                       | inty of Death                  |   |
| 270       |   |                               | 3107 Madison Pla  | ce   |                                   |                        | Hyat                      | tsv                    | ille                       |                         |                                 | Pri                           | ice Geo                        | orge's  |
| *.        | Funeral   |                               |   | Sex 7. Ag<br>1 ☐ M 2 🖾 F                       | e (In yrs. last bin               |                        | If Under                  | 1 Year<br>Days         | If Under                   | 24 Hrs.<br>Min.         | 8. Date of Bird<br>(Month, Da   | th<br>y, Year)                | 9. Birthp                      | place (State or Foreign                         |
| Diff.     | Director  |                               | 5/8-48-4286   | 1 L M 2 L F                                    | 68                                | Yrs.                   |                           |                        |                            |                         | Sept.                           |                               | 7 Wis                          | consin  |
|           | pu *  |                               | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town                   | n or l oc              | ation                     |                        |                            |                         |                                 | -                             | 1                              | Od. Inside City Limits                          |
|           | aryla<br>•ho  | 2                             |   |  |                                   |                        |                           |                        |                            |                         |                                 |                               | 1                              | 1 X Yes 2 □ No                                  |
|           | Me M  | ecto                          | Maryland Prince   | George's                                       | Hyatts                            | svil                   | _                         |                        |                            |                         |                                 | 40 000                        | / LUB                          |   |
|           | with t  | ā                             | 10e. Street and Number  | -  |                                   |                        | 10f. Zip                  |                        |                            |                         |                                 |                               | of What Cour                   | itry ?  |
|           | a 234   | rai                           | 3107 Madison P  | <del></del>                                    | Survius II O                      | 40.14                  |                           | 0782                   |                            | -:-0 (0                 | -4. V N                         | U.S.A                         |                                |   |
|           | er de   | une                           | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?              |                                   | 13. W                  | Yes, spec                 | fy Cubar               | spanic Orig<br>n, Mexican  | gin? (Spe<br>n, Puerto  | ecify Yes or No<br>Rican, etc.) | - 14.                         | Race - Americ<br>Black, White, |   |
| 36        | rs aft  | λF                            | 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced  | 1 Tes 2 XIII                                   | NO                                | 1                      | ☐ Yes 2                   | No KD                  | Specify:                   |                         |                                 | Spe                           | ocity: Wh:                     | ite   |
| 5-0036    | within 72 hours after death with the Maryland<br>she.<br>than "natural", or items 23s or 28s-f show<br>in Mudical Examinar trival by codified at  | Completed by Funeral Director | 15. Decedent's E  |  | 16a                               | Decede                 | ent's Usual               | Occupa                 | tion                       |                         |                                 | 16b Kind o                    | f Business/in                  |   |
| 215       | in 72<br>"na<br>tedic   | ojet                          | (Specify only highest gr  | ade completed)                                 |                                   | (Give k<br>lite. D     | and of wor<br>O NOT us    | k done d<br>e retired) | uring mosi                 | t of worki              | ng                              | 100.1010                      |                                | sastry  |
| 212       | filed with<br>Hygiene.<br>Ither the   | E                             | Elementary/Secondary (0-12)   | College (1-4or !                               |                                   | mem                    | aker                      |                        |                            |                         |                                 | Own F                         | Iome                           |   |
|           | Hygin<br>other  | BeC                           | 17. Father's Name (First, Middle, Las   | 1)   |                                   |                        |                           |                        | 18. Mothe                  | r's Name                | (First, Middle,                 |                               |                                |   |
| lan       | Mental Mental arked o   | To B                          | Evan Mason  |  |                                   |                        |                           | _                      | Jose                       | ephi                    | ne Brow                         | m                             |                                |   |
| Maryland  | 2 shou<br>and M<br>le mar<br>aumat  | -                             | 19a. Informant's Name/Relationship  | (Type, Print)                                  | 19b                               | . Mailing              | Address                   | (Street a              |                            | -                       | I Route Numbe                   |                               | wn, State, Zip                 | Code)   |
| Σ         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatth and Mental Hygjene. Department of Heatth and Mental Hygjene. Inportant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show may Injury or other traumatic event, the Medical Explinar minutes collined at ance. |                               | Mary C. Kirby -   | Daughter                                       | 31                                | 85 1                   | Mary1                     | and                    | Aven                       | ue.                     | Port Re                         | nublic                        | Marv                           | land 20676                                      |
| ē,        | s 1 a<br>f Hei<br>Item<br>otha  |                               | 20a. Method of Disposition  |  | 20b. Place of                     | Dispos                 |                           | e of                   |                            |                         | ate                             |                               | on - City or To                |   |
| 9         | Page<br>ent o<br>nt: If<br>ry or  |                               | 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci  |  |                                   |                        | ,                         |                        |                            | 19/14                   | 3/2005                          | A 1 03/2                      | ndrio                          | Virginia  |
| Baltimore | permit. Pages 1 and 3<br>Department of Health<br>Important: If Item 27<br>eny Injury or othar tr<br>once.   |                               | 21. Signature of Funeral Service Lice   |  | песторо                           | 22.                    | Name and                  | d Addres               | s of Facilit               | y Gas                   | sch's F                         | uneral                        | Home.                          | P.A.  |
| ä         | Departiment Important   |                               | Vich Ale  | 100  | 373                               |                        |                           |                        |                            |                         |                                 |                               |                                | D 20781   |
| - 6       |   |                               | 23a. Part1. Enter the disease, in conshock, or heart failure. List only   |  |                                   |                        |                           |                        |                            |                         |                                 |                               | 100000 III                     | Approximate                                     |
|           | Physician   |                               | Immediate Cause (Final  | one cause on each li                           | ne.                               | 11                     | P                         | 010                    | -                          | ea.                     |                                 | CAMI                          | 000                            | Interval Between<br>Onset and Death             |
|           | /Medical  |                               | disease or condition resulting in death)  | a. Due to (or as                               | a consequence                     | of):                   | , ,                       |                        | 101                        | ( VI                    |                                 | CVIII                         | 212                            |   |
|           | Examiner  |                               |   | Him  | 00M                               | PN                     | 181                       | $f_{\Lambda\Lambda}$   |                            |                         |                                 |                               |                                |   |
| 9         | <b>新</b>  | ē                             | Sequentially list conditions, if any, leading to immediate  | Due to (of as                                  | a consequence                     | of):                   | 101                       | V Y 1                  |                            |                         |                                 |                               |                                |   |
|           | outed<br>Id<br>ansit  | Examiner                      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | un   | NR C                              | lu                     | des                       | ter                    | RON                        | Mc                      |                                 |                               |                                |   |
| 0,        | ate be executed<br>hysician and<br>the burial-transit   |                               | resulting in death) Last  | Due to (or as                                  | a consequence                     | ol):                   | . [ 3                     |                        | ^                          | 0.                      |                                 |                               | 2.                             |   |
| 120       | te be<br>ysici  | cai                           |   | o. Clvo  | WK (                              | 10                     | 7W                        | 170                    | M                          | 10                      | VVYIC                           | mt                            | Xelo                           | nl  |
| 99        | tifica<br>ig ph<br>as th  | led                           |   |  |                                   |                        |                           |                        |                            |                         |                                 | 0                             | Manager                        |   |
| Вох       | The law requires that the death certifica<br>ate has been signed by the attending ph<br>page 2 should be detached for use as ft   | by Physician/Med              | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome                           | of pregnancy<br>2 Fetal death     | 3 🗆                    | Ectopic pre               | nnancv                 |                            |                         |                                 | 23d.                          | Date of delive                 | •   |
|           | deat  | sicie                         | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4☐Pregnant at<br>9☐Unknown                     |                                   |                        | Other (spe                |                        |                            |                         |                                 |                               | Month                          | Day Year  |
| P.0       | at the<br>by the  | hy                            | 9 🗆 Unknown   | 3EJ GIIKIIOWII                                 |                                   |                        |                           |                        |                            |                         |                                 |                               |                                |   |
|           | gned<br>gaded   | by F                          | Part II. Other significant conditions   | contributing to death b                        | ut not resulting in               | n the un               | derlying ca               | iuse give              | n in Part I.               |                         | 23e. Did to                     | obacco use c                  | ontribute to th                | ne cause of death?                              |
| ord       | equir<br>en si<br>ould  |                               |   |  |                                   |                        |                           |                        |                            |                         | 1 🗆 ۱                           | res 2□No                      | 3 Prob                         | ably 4 Unknown                                  |
| Records,  | law rass be   | pie                           |   |  |                                   |                        |                           |                        |                            |                         | 24a. Was                        |                               |                                | psy findings available<br>impletion of cause of |
|           | sician: The law<br>certificate has t<br>irector, page 2 s   | Completed                     |   |  |                                   |                        |                           |                        |                            |                         | perto                           | rmed?                         | death?                         |   |
| Vital     | Physician:<br>this certificanal director,   | Be (                          | 25. Was case referred to medical examiner?  |  |                                   |                        |                           | T. De-to               | 26. Place                  | of Death                | Check only o                    |                               |                                |   |
| f V       | nysic<br>direc  | 10                            | 1 Yes 2 No  | Hospital: 1   Inpatie                          | ent 2 ER/Ou                       | itpatient              | 3 DO                      | A Othe                 | r: 4 □ Nu                  | rsing Ho                | ne 5 Resid                      | dence 6 🗆                     | Other (Specify                 | y)  |
| n of      | ding Physician:<br>h.<br>After this certific<br>funeral director,   | ü                             | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Inju<br>(Month, Da                | ry 28b. T                         | Time of                | 28                        | Bc. Injury<br>Work     | at ?                       |                         | 28d. Describe I                 | now injury oc                 | curred                         |   |
| 0,0       | Attending of death.   | atic                          | 2 Accident investigation  | n  |                                   |                        | М                         | 1 🗆 Y                  | ′es 2 🗆 1                  | No                      |                                 |                               |                                |   |
| Division  | or Att  | ŧ                             | 3 Suicide 6 Could not l<br>4 Homicide determined  | 280. Place of In                               | ury - At home, fa<br>c. (Specify) | ırm, stre              | et, factory,              | office                 |                            |                         | 28f. Location (5<br>City or Tox | Street and Nu<br>vn, State)   | imber or Rura                  | l Route Number,                                 |
|           | ral D   | Ce                            | · · · · · · · · · · · · · · · · · · ·   |  |                                   |                        |                           |                        |                            |                         |                                 |                               |                                |   |
|           | To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the  | Medical Certification:        | (Check only 2 Medical Exa   | hysician: To the best<br>miner: On the basis o | f examination and                 | e, death<br>id/or inve | occurred a<br>estigation, | at the tim<br>in my op | e, date and<br>inion, deat | d place, a<br>th occurr | and due to the and at the time, | cause(s) and<br>date and plac | manner as st                   | ated.<br>the cause(s)                           |
|           | the<br>the<br>the   | Med                           | one) 29b. Signature and title of certifier  | and manner st                                  | ated.                             |                        | 200                       | License                | numbar                     |                         |                                 | Ind Data sis                  | and Alasth                     | Day Vand  |
|           | Met To To To To To To To To To To To To To  |                               | 250. Signature and title of certifier   | TION   | m                                 |                        | 290.                      | LICEISE                | Land C                     | 0                       |                                 | _                             | ned (Month,                    | -   |
|           | (12)  |                               | o i new   | (M)  | '1                                |                        | 1 4                       | 141                    | 044                        | 10                      | 3                               | uce                           | mbe                            | K 10,2005                                       |
| 2         | (10)  |                               | 30. Name and address of person who S+WM T.  | completed cause of c                           | leath (Item 23a) (                | (Type, P               | Print)                    | 18                     | T                          | 441                     | 11/201                          | 16 r                          | 40 2                           | R 10,2005<br>0782                               |
|           | Sta<br>Registi  |                               | 31. Date filed (Month, Day, Year)  DEC 1 4 20   | Registr  | ar's Signature                    | die                    | L                         |                        |                            | 1                       |                                 |                               |                                |   |

|                     |   | ļ              | 1 - For<br>State<br>Registrar  | State of M   | Maryland /                            | Depa<br>Cer            | artmeni<br>rtificate               | t of H                       | ealth a<br>Death           | and Me                   |   | giene<br>Reg. No.                   | 005  | 1, 2                          | 385                         |
|---------------------|---|----------------|--|--|---------------------------------------|------------------------|------------------------------------|------------------------------|----------------------------|--------------------------|---|-------------------------------------|--|-------------------------------|-----------------------------|
| Ä                   | Dhusisi   |                | 1. Decedent's Name (First, Middle, L   | .ast)  |                                       |                        |                                    |                              |                            |                          | 2. Date of Dea                              |                                     | Year   | 3. Tim                        | e of Death                  |
|                     | Physici<br>/Medio   |                | Flordine   | G.   |                                       |                        | ost                                |                              |                            |                          | December                                    | 11, 2                               | 005  | 13                            | 30 M                        |
|                     | Examir  | 10             | 4a. Facility Name (If not institution, g<br>Anne Arundel Medica  |  | ər)                                   |                        | Anna                               | polis                        |                            |                          |   | Ann                                 | ounty of Death<br>e Arunde                         | 1                             |                             |
|                     | Funeral<br>Director   |                | 579-42-7198  | Sex 7.<br>1 □ M 2 □ F  | Age (In yrs. last b                   | vrs.                   | If Under<br>Months                 | 1 Year<br>Days               | If Under:<br>Hours         | Min.                     | 8. Date of Birtl<br>(Month, Day<br>December | 28, 1                               | 9. Birth<br><i>Cou</i>                             | place (Sta<br>ntry)<br>New Yo | te or Foreign<br>ork        |
|                     | Aaryland<br>Fahow   | or             | Usual Residence of Decedent  10a. State 10b. County  Maryland Prince (                                       | leorge†s   | 10c. City, To                         |                        | cation<br>1boro                    |                              |                            |                          |   |                                     |  |                               | e City Limits               |
|                     | the N   | Director       | 10e. Street and Number   |  | ОРРС                                  |                        | 10f. Zip                           | Code                         |                            |                          |   | 10a, Citize                         | n of What Cou                                      |                               |                             |
|                     | 3a or   |                | 10800 Knoll Court  |  |                                       |                        |                                    | 0772                         |                            |                          |   | US                                  |  | ,                             |                             |
| 336                 | be filed within 72 hours after death with the Maryland<br>hat Hygiene.<br>Id other than "natural", or items 23e or 28e-f ahow<br>event, ite Madical Evaninar must be notilited at | by Funeral     | 11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced                                   | 12. Was Decede<br>Armed Force<br>1 ☐ Yes 2<br>If Yes, Give<br>Year or Date | s?<br>ZMNo                            | '                      | Was Deced<br>f Yes, spec           | ify Cubar                    | spanic Origin, Mexican     | gin? (Spec<br>, Puerto R | ify Yes or No-<br>ican, etc.)               |                                     | Race - Ameri<br>Black, White,                      |                               | 1,                          |
| Ö                   | 2 hou   | ted            | 15. Decedent's   |  | 16                                    |                        | dent's Usua                        |                              |                            | t of workin              | _   | 16b. Kind                           | of Business/Ir                                     | ndustry                       |                             |
| Maryland 21215-0036 | od within 7<br>giene.<br>er than "n   | Completed      | (Specify only highest of Elementary/Secondary (0-12)   | College (1-4d  | or 5+)                                | life.                  | kind of wor<br>DO NOT us<br>Estate | e retired)                   |                            | t of working             | g   | Sale                                | es   |                               |                             |
| /land               | 2 should be filed<br>and Mental Hygi<br>Ia marked other<br>aumatic event, I   | To Be (        | 17. Father's Name (First, Middle, La.<br>Morris Goldstein  | st)  |                                       |                        |                                    |                              | _                          |                          | (First, Middle,<br>erstein                  | Maiden St                           | umame)   |                               |                             |
| lan                 | 2 sho<br>and I<br>Ia me   |                | 19a. Informant's Name/Relationship   | (Type, Print)  | 19                                    | b. Mailir              | ng Address                         | (Street a                    | nd Numbe                   | r or Rural               | Route Numbe                                 | r, City or T                        | οwπ, State, Ziμ                                    | Code)                         |                             |
| ≥,                  | rt 27   |                | Irwin Post / Husban  | d  |                                       |                        |                                    |                              | Upper                      |                          | oro, Man                                    |                                     | 20772  |                               |                             |
| more                | Pages 1 a<br>ent of Hea<br>nt: If item<br>ry or othe  |                | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec                         |  | te Marylar                            | ery, crer              | natory or of                       | her place                    |                            | c. 15,                   |   |                                     | ition - City or To<br>enham, Ma                    |                               |                             |
| Baltimore,          | permit. Pages :<br>Department of H<br>Important: If ite<br>any injury or ot   |                | 21. Signature of Funeral Service Lic   | ensee  |                                       | 22                     | . Name and                         | d Address                    | s of Facility              | y Georg                  | 100   | las Fur                             | neral Hon  | ne PA                         |                             |
|                     |   |                | 23a Part 1. Enter the disease, or co   | mplications that caus  | sed the death. Do                     |                        |                                    |                              |                            |                          |   |                                     | nd 2074  | Approxi                       |                             |
|                     | Physician<br>/Medical   |                | shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)    | a  | as a consequence                      |                        | roseps                             | دُدُ                         |                            |                          |   |                                     |  |                               | Between<br>nd Death         |
|                     | Examiner  |                | Conventially list conditions   | h  |                                       | , .                    |                                    |                              |                            |                          |   |                                     |  |                               |                             |
|                     | sit ad  | iner           | Sequentially list conditions, franchise added to minimalist cause. Enter Underlying Cause (Disease or injury | Due to (or   | as a loursequence                     | s of):                 |                                    |                              |                            |                          |   |                                     |  |                               |                             |
| ,                   | cate be executed<br>physician and<br>the burial-transit   | Examiner       | that initiated events<br>resulting in death) Last  | c.<br>Due to (or :   | as a consequence                      | e of):                 |                                    |                              |                            |                          |   |                                     |  |                               |                             |
| 8760,               | cate be   | dlcal          |  | d  |                                       |                        |                                    |                              |                            |                          |   |                                     |  |                               |                             |
| .O. Box 6           | ne death certiff<br>the attending<br>thed for use as  | Physiclan/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ∑XNo 9 □ Unknown                      |  | 2 Fetal deat<br>at time of death      |                        | Ectopic pre<br>Other (spe          |                              |                            |                          |   | 230                                 | d. Date of delive                                  | ery<br>Day                    | Year                        |
| Δ.                  | quires that the signed by all be detacted   |                | Part II. Other significant conditions  BYEAST CALLY  |  | but not resulting                     |                        |                                    | iuse give                    | n in Part I.               |                          | 23e. Did to                                 | Ac*                                 | contribute to t                                    |                               | of death?                   |
| Vital Records,      | e law<br>has b  | Completed by   |  |  |                                       |                        |                                    |                              |                            |                          | 24a. Was a autops perform                   | an 2<br>sy<br>med?<br>2 <b>X</b> No | 24b. Were auto<br>prior to co<br>death?<br>1 ☐ Yes | mpletion o                    | gs available<br>of cause of |
| ital                | (0 -  | BeC            | 25. Was case referred to medical   |  |                                       |                        |                                    |                              | 26. Place                  | of Death (               | Check only or                               |                                     | 1 163  | 20 190                        |                             |
|                     | ya<br>dir   | ToE            | examiner?<br>1 ∐ Yes 2 🌠 No  | Hospital: 1 Kinpa  | itient 2 ER/O                         | utpatien               | t 3 🗆 DQ                           | A Othe                       | r: 4 🗖 Nui                 | rsing Hom                | e 5 ☐ Reside                                | ence 6                              | Other (Specif                                      | y)                            |                             |
| o uo                | Attending Planding Planding Planding Planding Planding Setor: After the by the funeral  |                | 27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigati  |  | njury 28b.<br>Day Year)               | Time of<br>Injury      | 28<br>M                            | 3c. Injury<br>Work'<br>1 □ Y |                            |                          | ld. Describe h                              | ow injury o                         | ccurred  |                               |                             |
| Division of         | i gitte   | Certification: | 3 Suicide 6 Could not determine  | d 286. Place of  | Injury - At home, i<br>etc. (Specify) | arm, str               | eet, factory,                      | office                       |                            | 28                       | If. Location (Si<br>City or Town            | treet and N<br>n, State)            | Vumber or Rura                                     | il Route N                    | umber,                      |
|                     | To the Hospital<br>within 24 hours a<br>To the Funeral I<br>completely filled   | edical (       | 29a. Certifier 1 Certifying F (Check only one) 1 Medical Extended  | Physician: To the be<br>aminer: On the basis<br>and manner                 | of examination a                      | ge, death<br>nd/or inv | occurred a                         | it the time<br>in my opi     | e, date and<br>inion, deat | d place, an              | d due to the c<br>I at the time, d          | ause(s) an<br>late and pla          | id manner as s<br>ace, and due to                  | tated.                        | e(s)                        |
| <b>,</b>            | To the To the comp  | M              | 29b. Signature and title of certifier  | erolBah, i   | Vo                                    |                        |                                    | License<br>Q                 | number<br>6052             |                          | 2   | 9d. Date s                          | igned (Month,                                      | Day, Year                     | )                           |
| )                   | (5)   |                | 30. Name and address of person who Sioth Ol Bech, i  | completed cause o  | f death (Item 23a)                    | (Type,                 | Print)<br>POLVEV                   | iay i                        | anu                        | afoci                    | i, Mb                                       |                                     |  |                               |                             |
|                     | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) DEC 1 4 20   |  | strar's Signatyre                     |                        |                                    |                              |                            |                          |   |                                     |  |                               |                             |

|                   |  |                  | 1- For State of Maryland   | Department of<br>Certificate of   |  | Reg.                                      | ne.2005  | 42386   |
|-------------------|--|------------------|--|---|--|---|--|---|
|                   | Physici<br>/Medio<br>Examin  | al               | 1. Decedent's Name (First, Middle, Last)  A162 r + Frank Rum  4a. Facility Name (If not institution, give street and number)   |   | or Location of Death   | 2. Date of Death<br>Month                 | Day Year S 2005                                  | <u> </u>                                      |
|                   | Funeral<br>Director  | ler              | 5. Social Security Number 6. Sex 7. Age (In yrs. last 214-14-6228 12 F 87  |   | Westmin<br>If Under 24 Hrs.  | 8. Date of Birth                          | C ZV   |   |
|                   | Maryland<br>a-f show   | ctor             |  | own or Location ew Windsor  |  |   |  | 10d. Inside City Limits<br>1 ☐ Yes 2 ☐ No     |
|                   | th with the<br>23e or 28   | Funeral Director | 10e. Street and Number<br>1542 Old New Windsor Pike  | 10f. Zip Code   | 21776  | 10g.                                      | . Citizen of What Cou                            | ntry?   |
| 2-0036            | within 72 hours after death with the Maryland<br>ene.<br>then "natural", or items 23e or 28a-f show<br>the Medical Exama for must be notified at   | by Funer         | 11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Myse 2 No If Yes, Give Year or Dates: 1942-45  |   | Hispanic Origin? (Spe<br>ban, Mexican, Puerto F<br>o <i>Specify:</i> | cify Yes or No-<br>Rican, etc.)           | 14. Race - Ameri<br>Black, White,<br>Specify: Wh |   |
| 21215-0           | ed within 72 ha<br>giene.<br>er then "natu<br>. the Medical  | Completed by     | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 10 College (1-4or 5+)   | 6a. Decedent's Usual Occi<br>(Give kind of work don<br>life. OO NOT use retir<br>OWner/mechan | e during most of workinged)  | )g  | b. Kind of Business/Ir                           | ice station                                   |
| Maryland          | ould be file<br>Mental Hy<br>arked oth   | To Be (          | William George Rumbold II  |   | 18. Mother's Name  | rmer                                      |  |   |
| , Mar             | and 2 sho<br>ealth and<br>n 27 te my<br>eer treums   |                  | Sharon Muller - niece  | 19b. Mailing Address <i>(Stree</i><br>600 Muller  | Rd., Westmi  | inster, M                                 |  | o Code)                                       |
| altimore,         | permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural; or items 23e or 28a-f show any injury or other treumatic event, the Medical Esantine must be notified at ance.  |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  | e of Disposition (Name of efery, crematory or other plane)  Creek Cem.  22. Name and Add      | 12/12<br>ress of Facility Ha   | 2/2005 n<br>artzler                       |  |   |
| 8                 | 9 9 E E  |                  | 23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.  |   | h St., New<br>ying, such as cardiac or                               |   |  | Approximate<br>Interval Between               |
| *                 | rnysician<br>/Medical<br>Examiner  |                  | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence)  | Sepsis  |  |   | T and  | Onset and Death 24 No45                       |
| 8760,             | The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit   | dicai Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of the |   |  |   |  |   |
| P.O. Box 6        | that the death certificated by the attending placed by the attending placed for use as t   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 9 ☐ Unknown  | ath 3 Ectopic pregnan   | осу  |   | 23d. Date of deliv<br>Month                      | ery<br>Day Year                               |
|                   | w requires that<br>s been signed b<br>should be deta   | by               | Part II. Other significant conditions contributing to death out not resulting  | g in the underlying cause g   | given in Part I.   | 23e. Did tobac                            | co use contribute to t                           | he cause of death?                            |
| al Records,       | : The law re<br>cate has bee<br>, page 2 sho   | Completed        |  |   |  | 24a. Was an autopsy performed             | prior to co                                      | opsy findings available impletion of cause of |
| Division of Vital | To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the tuneral director, page  | atlon: To Be     |  | b. Time of linjury W  |  | ,   | e 6 ∏Other (Special                              | ýy)   |
| Divis             | el or Attendi<br>s after death.<br>Il Director: A<br>id in by the fu   | Certification:   | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of frieury - At home, building, etc. (Specify)   | , farm, street, factory, office   | 9 2  | 8f. Location (Stree<br>City or Town, S    | t and Number or Run<br>State)                    | al Route Number,                              |
|                   | To the Hospitel within 24 hours a To the Funeral I completely filled   | edical (         | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.  | dge, death occurred at the and/or investigation, in my  | time, date and place, a<br>r opinion, death occurre                  | nd due to the caus<br>d at the time, date | e(s) and manner as s<br>and place, and due t     | tated.<br>o the cause(s)                      |
|                   | P TITLE OF THE PERSON NAMED IN PROPERTY OF THE PERSON NAMED IN | Ň                | 29b. Signature and title of certifier  | I   | nse number<br>5059993  |   | Date signed (Month,                              |   |
|                   | Was  |                  | 30. Name and address of person who completed cause of death (Item 23)  | Are. Suite  | 307 ~ 5  | et z n'enti                               | y MO   | 21157   |
|                   | Sta<br>* Registr   |                  | 31. Date filed (Month, Day, Year)  DEC 1 3 2005  32. Registrar's Signature   | & Soule   |  |   |  |   |

|                                |   |                |  | epartment of Health and Mental I   | 7005 67387   |
|--------------------------------|---|----------------|--|--|--|
|                                | Physici   | an             | Decedent's Name (First, Middle, Last)  | 2. Date o  | Day Year   |
|                                | /Medic  | al             | EUGENE N. ROBINSON,  4a. Facility Name (If not institution, give street and number)  | JR. Dece   | mber 14,20054:38 a M   |
|                                | Examir  | er             |  | 4b. City, Town, or Location of Death  CLINTON  | 4c. County of Death PRINCE GEORGES   |
|                                | Funeral   |                | SOUTHERN MARYLAND HOSPITAL  5. Social Security Number 6. Sex 7. Age (in yrs. last birth  | nday) If Under 1 Year   If Under 24 Hrs.   8 Date of   |  |
|                                | Director  |                | 577-78-7622   189 M 2 L F   51 Y   | <sup>7</sup> rs. 9-0   | 9-1954 VIRGINIA  |
|                                | yland   |                | 10a. State 10b. County 10c. City, Town   | or Location  | 10d. Inside City Limits  |
|                                | 8a-f •  | Director       | MD PRINCE GEORGES OXON   | HILL   | 1 ☐XYes 2 ☐ No   |
|                                | with the  |                | 10e. Street and Number 644 AUDREY LANE, #201   | 10f. Zip Code  | 10g. Citizen of What Country?  |
|                                | death<br>ms 23  | Funerai        | 11 Marital Status 12 Was Decedent Ever in U.S.   | 20745  13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.   | U.S.A. or No- 14. Race - American Indian,  |
| 36                             | or Ite  | y Fu           | 1 Never Married 2 Married 1 Yes 2 Moo If Yes, Give Year or Dates:  | If Yes, specify Cuban, Mexican, Puerto Rican, etc.  1 ☐ Yes 2 ☑ No Specify:  |  |
| Ş                              | be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23s or 28s-f show event, the Medical Examiner cast be notified at          | ed by          |  | Decedent's Usual Occupation  | Specify: BLACK  16b. Kind of Business/Industry                                     |
| 215                            | hin 72<br>9.<br>9n "na<br>Madic   | Completed      | (Specify only highest grade completed)   | Give kind of work done during most of working<br>life. DO NOT use retired)   | Tob. Kind of Business/Industry   |
| 2                              | 2 0 a   | Сод            | 12th COM   | IPUTER SPECIALIST  | VERIZON  |
| and                            |   | Be C           | 17. Father's Name (First, Middle, Last) EUGENE N. ROBINSON, SR.  | 18. Mother's Name (First, Mic  |  |
| ary.                           | 2 should<br>and Men<br>is marke<br>eumatic  | 2              | 19a. Informant's Name/Relationship (Type, Print)  19b. 1   | Mailing Address (Street and Number or Rural Route Nu   | umber, City or Town, State, Zip Code)  |
| Baltimore, Maryland 21215-0036 | コモトコ  |                | GLENDA HILTON-ROBINSON-WIFE 6  | 44 AUDREY LANE, #201   | OXON HILL, MD 20745  |
| ore                            | Pages 1 and<br>ment of Healt<br>ant: if Item 2:<br>ary or other   | Ш              | 1 X Burial 2 Cremation 3 Removal from State  | Disposition (Name of Date , crematory or other place)  | 20c. Location - City or Town, State  |
| ## E                           | permit. Pag<br>Department<br>Important:<br>any injury o   |                | 4 □ Donation 5 □ Other (Specify) FT . LI  21. Signature of Fungral Service □ Service | NCOLN CEM. 12/20/05  22. Name and Address of Facility TAYLOF   | BRENTWOOD, MARYLAN   |
| Ba                             | Depart Impo   |                |  | 1722 NORTH CAPITOL ST  | R'S FUNERAL HOME   |
|                                |   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  |  |  |
|                                | Physician   |                | Immediate Cause (Final disease or condition  |  | Onset and Death  |
| ī                              | /Medical<br>Examiner  |                | resulting in death)  Due to (or as a consequence of  | ):   |  |
|                                | n T   | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter underlying   | ):   |  |
|                                | acuted<br>ind<br>transit  | Examine        | Cause (Disease or injury that initiated events c.  |  |  |
| 8/60,                          | cate be executed<br>physicien and<br>the burial-transit   | a<br>E         | Due to (or as a consequence of   | ):   |  |
| 289                            | certificate be executed vding physicien and ise as the burial-transit   | edical         | , d.   |  |  |
| XOR                            | death certifica<br>ettending ph<br>for use as th  | hysician/Me    | IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  1 □ Live birth 2 □ Fetal death   | 3 Ectopic pregnancy  | 23d. Date of delivery  |
| j<br>L                         | 0 0 0   | sici           | in the past 12 months?  1  | 5 Other (specify)  | Month Day Year   |
| S,                             | requires that the deren signed by the e   | ٥.             | Part II. Other significant conditions contributing to death but not resulting in t   | he underlying cause given in Part I. 23e. D  | Did tobacco use contribute to the cause of death?                                  |
| rds                            | w requires<br>been sign<br>should be  | Completed by   | CHRONIC RENAL FAILURI  | E, ACQUIRED  | ☐ Yes 2 12 No 3 ☐ Probably 4X☐Unknown  |
| ecord                          | > 0 70  | plet           | IMMUND DEFICIONCY SYND   | ROME, 24a. W   | Vas an utopsy 24b. Were autopsy findings available prior to completion of cause of |
| Ē                              | ilcian: The lav<br>certificate has<br>rector, page 2 :  |                | PANCYTOPENIA   | Di Di  | erformed? death? X es 2 No 1 Yes 2 No  |
| Vitai                          | s certif  | o Be           | 25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 1 Inpatient 2 ER/Outp  | 26. Place of Death (Check on |  |
| 0                              | g Phy<br>ter this   | n: To          | 27. Manner of Death 28a. Date of Injury 28b. Tin   | ne of 28c. Injury at 28d. Descrit  | tesidence 6 Other (Specify) be how injury occurred                                 |
| SIO                            | eath.<br>tor: Af<br>the fur   | catic          | 2 Accident investigation   | M 1 ☐ Yes 2 ☐ No   |  |
| DIVISION                       | or At<br>after d<br>Direct<br>in by   | Certification: | 4 Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)  |  | on (Street and Number or Rural Route Number.<br>Town, State)                       |
|                                | To the Hospital or Attending Physicien: Ti<br>within 24 hours after death.<br>To the Funerel Director: After this certificate<br>completely filled in by the funeral director, pa |                | 29a. Certifier 1 Wertifying Physician: To the best of my knowledge,  | death occurred at the time, date and place, and due to t   | the cause(s) and manner as stated.   |
|                                | the Ho<br>the Fu<br>the Fu  | edical         | one) and manner stated.  | or investigation, in my opinion, death occurred at the time  | ne, date and place, and due to the cause(s)  |
| v                              | To To Con   | Σ              | 29b. Signature and title of cartifier  ATTENDING P   | 29c. License number  | 29d. Date signed (Month, Dey, Year)  |
| 0                              | (2)   | }              |  | D32900   | 12-14-05   |
| _                              | 0   |                | MUSA MOMOH MD 8700 CENTI   | RAL AV H 301, LANDO  | NER MD 20785   |
|                                | Stat<br>Registra  |                | 31. Date filed (Month, Day, Year) 37 Registrar's Signature DEC 1 6 2005  | fore   |  |

|  |                | 1 - For<br>State<br>Registrar  | <del></del>  | partment of Health and<br>ertificate of Death  | Re   | g. No.   |
|--|----------------|--|--|--|--|--|
| Phys   | ician          | 1. Decedent's Name (First, Middle, Las                                       | n<br>ene Richardson  |  | 2. Date of Death<br>Month                        | Day Year   |
|  | dical<br>niner |  |  | 4b. City, Town, or Location of De  | Decembe:   | r 9 2005 6:00 A M  |
| LXaji  | mie            |  | n Health Center  | Fort Washin  |  | Prince George's  |
| Funer  |                | 5. Social Security Number 6. Security Number 142-52-4562                     | 7. Age (In yrs. last birthday 7. The state of the state o | ) If Under 1 Year If Under 24 H<br>Months Days Hours Mi                                  |  | 9. Birthplace (State or Foreign                                      |
| pu ,   |                | Usual Residence of Decedent  10a. State 10b. County                          | 10c. City, Town or L   |  |  |  |
| Aaryla<br>F shoved   | ō              |  |  |  |  | 10d. Inside City Limits 1 ∑X es 2 □ No                               |
| the N  | Directo        | Maryland Prince (  | George's   | Oxon Hill  10f. Zip Code   | 10   | g. Citizen of What Country?  |
| th with  | aD             |  | Ave., #2   | 20745  |  | United States  |
| n 72 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>edical Examinet must be notified at                           | y Funeral      |  | 12. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:   | Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put 1 Yes 2 No Specify: | Specify Yes or No-<br>erto Rican, etc.)          | 14. Race - American Indian, Black, White, etc.  Specify: Black       |
| hours<br>tural'  | ed by          | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed                                  |  | edent's Usual Occupation   |  |  |
| c * 3  | Completed      | (Specify only highest grad   | de completed) (Give  | e kind of work done during most of w<br>DO NOT use retired)                              | orking   | 6b. Kind of Business/Industry  |
| ifiled within<br>I Hygiene.<br>other then "  | mo             | Elementary/Secondary (0-12)<br>12th  | College (1-4or 5+)   | Laborer  |  | Government   |
| be filed<br>ttal Hygi<br>d other   | Be             | 17. Father's Name (First, Middle, Last)                                      |  | 18. Mother's N   | ame (First, Middle, M                            | laiden Surname)  |
|  | 2              | George Richar  |  |  |  | le Williams  |
| s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic  |                | 19a. Informant's Name/Relationship (7 Sharon R. Richards                     | son/Daughter 3   | ing Address <i>(Street and Number or I</i><br>354 <b>Curtis</b> Dr., #                   | T-1, H1110                                       | crest Hgts., Mi) 20746   |
| Pages 1<br>nent of H<br>int: If ite  |                | 20a. Method of Disposition 1   | Removal from State   | osition (Name of<br>ematory or other place)  | Date 2   | Oc. Location - City or Town, State                                   |
| it. Pa<br>rtmer<br>rtent   |                | * 4 □ Donation 5 □ Other (Specify)  21. Signature of runeral Service License |  | Veterans Cem. 12   |  | Cheltenham, MD   |
| permit. Pages<br>Dep: rtment of<br>Importent: If I<br>any Injury or  | SUC            | 21. Signature of Furieral Service Licens                                     | t. VIII  |  |  | uneral Home<br>Wash., DC 20019                                       |
|  |                | snock, or near failure. List only o  | lications that caused the death. Do not en<br>ne cause on each line.   |  |  |  |
| Physicia<br>/Medica  | _              | Immediate Cause (Final disease or condition resulting in death)              |  | ffuse metastasis   |  | 2 months   |
| Examine  |                |  | Due to (or as a consequence of):   | #1900M   |  |  |
|  | le le          | Sequentially list conditions,  | b. Pulmonary Etubo Due to (or as a consequence of)   | lism   |  | 2 weeks  |
| ficate be executed<br>physician and<br>the burial-transit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events       | С.   |  |  |  |
| ificate be executed<br>g physician and<br>as the burial-transit  |                | resulting in death) Last   | Due to (or as a consequence of):   |  |  |  |
| cate b   | edical         |  | d  |  |  |  |
|  |                | IF FEMALE:   | 23c. If yes, outcome of pregnancy  |  |  | 2018-11  |
| The law requires that the death certif<br>ate has been signed by the attending<br>page 2 should be detached tor use ar                             | hysician/M     | in the past 12 months?   | 1 Live birth 2 Fetal death 3   | □Ectopic pregnancy □ Other (specify)   |  | 23d. Date of delivery  Month Day Year                                |
| s that<br>ned b<br>e deta  | by Pi          |  | ntributing to death but not resulting in the u   | inderlying cause given in Part I.  | 23e. Did toba                                    | acco use contribute to the cause of death?                           |
| en sig   |                |  |  |  | 1. X Yes   | 2 No 3 Probably 4 ☐Unknown   |
| law re<br>as be<br>2 sho   | ompleted       |  |  |  | 24a. Was an autopsy                              | 24b. Were autopsy findings available prior to completion of cause of |
|  | Com            |  |  |  | performe   | death?  No 1 Ves 2 No  |
| Physicien: The lav<br>this certificate has<br>ral director, page 2   | Be             | 25. Was case referred to medical examiner?                                   | 4  |  | ath (Check only one)                             |  |
| Physi<br>this c  | 2              | 1 ☐ Yes 2 📉 No  27. Manner of Death  | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of  |  | 7  | ce 6 □Other (Specify)  |
| ding<br>h.<br>After<br>tuner   | tlon           | t XNatural 5 ☐ Pending   | (Month, Day Year) Injury   | of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No  | 28d. Describe how                                | injury occurred  |
| l or Atten<br>atter deal<br>Director:  | ertification:  | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined      | 28e. Place of Injury - At home, farm, str<br>building, etc. (Specify)  |  | 28f. Location (Stre<br>City or Town,             | et and Number or Rural Route Number,<br>State)                       |
| To the Hospitel or Attending Phys<br>within 24 hours after death.<br>To the Funerel Director: After this<br>completely filled in by the tuneral di | edical Co      | 29a. Certifier 1 Certifying Phy (Check only one)                             | sician: To the best of my knowledge, deat<br>ner: On the basis of examination and/or in<br>and manner stated.  | h occurred at the time, date and place vestigation, in my opinion, death occ             | e, and due to the cau<br>urred at the time, date | se(s) and manner as stated.<br>e and place, and due to the cause(s)  |
| ro the   | Mec            | 29b. Signature and title of certifier  |  | 29c. License number  | 290  | d. Date signed (Month, Day, Year)                                    |
|  |                | Mon  | 2/   | D24535   |  | December 14, 2005  |
| (4)  |                | 30. Name and address of person who ca  | ompleted cause of death (Item 23a) (Type,  | Print)   |  |  |
| 0  |                | Laxmi N. Berwa   |  | ranch Ave., #C-10  | l, Clinton                                       | n, MD 20735  |
| Regis  | tate           | 31. Date filed (Month, Day, Year) <b>DFC 1 6</b> 2005                        | 2. Registrar's Signature   | Ri   |  |  |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Thelma Juanita Ray 8 2005 8:35 /Medical December 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sligo Creek Nursing & Rehab. Ctr. Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 XF Director Yrs 084-32-7506 65 Feb. 26, 1940 Alabama Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic avent, the Madical Examinar must be notified at 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Takoma Park Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? with 7525 Carroll Ave. 20901 United States death Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 No 3 ☐ Widowed 4 N Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Domestic Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Berk Norwood Portia Malone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iges 1 and 2 sl nt of Health an Michael K. Ray/Son 7728 Woodmont Ave., Bethesda, MD A. Pages 1 a. Jepartment of Her Important: If?

any injur 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory 12/16/2005 Clinton, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home M evier 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Breast Cancer /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit The law requires that the death certificate be executed Hypertension Due to (or as a consequence of): aftending physician Box 68760 hysiclan/Medicai the IF FEMALE - esr 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Division of Vital Records, P.O. detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy performed? Yes 2 X No certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: After 28d. Describe how injury occurred Injury 1 XNatural 5 Pending death. 1 □ Yes 2 □ No investigation 2 Accident Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 \ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) 🕯 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D46998 December 12, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3415 Hamilton St., #1, Hyattsville, MD Steven T. Tee, M.D. 31. Date filed (Month, Day, Year) State 15 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Jeannette Amelia Rholetter 19 2005 December 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ruxton Health of Denton Denton Caroline 5. Social Security Number If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗓 F Months Hours Min Director 204-32-3054 62 Pennsylvania 1943 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla poperment of Health and Mental Hygiene. Important: If the 27 is marked other than "natural", or items 23e or 28e1-show any injury or other traumatic event, the Maricel Examine must be notified as 1 ☐ Yes 2 No Maryland Caroline Henderson Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16553 Henderson Road 21640 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 product handling Solo Cup Corp 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) George Riddle ္ပ Betty Hendricks Riddle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clark H. Rholetter, husband 16553 Henderson Road Henderson, Maryland 21640 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Chester Cremation Cn 12/22/05 Chester, Maryland 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
PO Box 160 Greensboro, MD 21639 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DAY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **S**Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No cate has l 24a. Was an certificate 21 No 1 Yes 25 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes Certification: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation after death.

Director: A
In by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide hours after within 24 hours a To the Funeraf I Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Federalsburg Reinbo 321 31. Date filed (Month, Day, DEC 2 32. Registrar's Signature Year) State Registrar

|                            |   |                | 1 - For State Registrar  | State of Marylar  |                                   | artment of H   |                                      |  | giene 00                                   | 5 42391   |
|----------------------------|---|----------------|--|---|-----------------------------------|--|--------------------------------------|--|--|---|
|                            |   |                | Decedent's Name (First, Middle, Last)  |   |                                   |  |                                      | 2. Date of Dea   | ıth  | 3. Time of Death  |
|                            | Physici<br>/Medio   |                | Ruth Eller   | n Roupp   |                                   |  |                                      | Dec.   | 17. 200                                    | ( 1 1 1 M   |
|                            | Examir  |                | 4a. Facility Name (If not institution, give si   | treet and number)   |                                   | 4b. City, Town, o  | r Location of De                     |  | 4c. County of E                            | Peath   |
|                            |   |                | 5340 River Road  | i   |                                   | Hurl   |                                      |  | Dorch                                      | ester   |
|                            | Funeral   |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs.   |                                   | If Under 1 Year<br>Months Days                               | If Under 24 H                        | in. (Month, Day  |  | Birthplace (State or Foreign<br>Country)                |
|                            | Director  |                | 103-30-9346  | M 2LJK- 43  | Yrs.                              |  |                                      | Jan.31   | ,1962 P                                    | ennsylvania   |
|                            | and   |                | Usuel Residence of Decedent  10a. State 10b. County  | 10c. C  | ity, Town or Lo                   | cation   |                                      |  |  | 10d. Inside City Limits                                 |
|                            | Mary  | ō              | MD Dorches   | star  |                                   | Hurloc   | k                                    |  |  | 1 ☐ Yes 2 🙀 No  |
|                            | 28a   | Director       | 10e. Street and Number   | 3001  |                                   | 10f. Zip Code  | . IC                                 |  | 10g. Citizen of What                       | Country?  |
|                            | 3a o  |                | 5340 River Roa   | a d   |                                   | 21   | 643                                  |  | United                                     | States  |
|                            | me 2  | Funeral        | 11. Marital Status   | 2. Was Decedent Ever in L   | J.S. 13.                          | Was Decedent of H  | lispanic Origin?                     | (Specify Yes or No-  |  | merican Indian,   |
| 9                          | or its  | F              | 1 → Never Married 2 ☐ Married  | Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give                                 | 1                                 | If Yes, specify Cub<br>1 ☐ Yes 24☐kNo                        | Specify:                             | erto Hican, etc.)  |  | /hite, etc.   |
| 8                          | irel',  | d by           | 3 Widowed 4 Divorced   | Year or Dates:  |                                   | I I I I I I I I I I I I I I I I I I I                        | Specify.                             |  | Specify:                                   | White   |
| 2                          | within 72 hours after death with the Maryland<br>ene.<br>then "neturel", or iteme 23e or 28e-f ehow<br>fre Medical Exercites mail be notilled at  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)   | 16a. Dece                         | dent's Usual Occup<br>kind of work done<br>DO NOT use retire | ation<br>during most of w            | vorking  | 16b. Kind of Busine                        | ess/Industry  |
| 7                          | Mithin<br>De.   | du             | Elementary/Secondary (0-12)  | College (1-4or 5+)  |                                   | abled  | a)                                   |  | N/A  |   |
| N<br>T                     | Hygie<br>Hygie<br>Ither I   | ပ္ပ            | 17. Father's Name (First, Middle, Last)  |   | DIS                               | abled  | 18 Mother's N                        | lame (First, Middle,   |  |   |
| Maryland 21215-0036        | ontal i   | Be c           | Keith Roupp  |   |                                   |  |                                      | Burgess  |  |   |
| <u> </u>                   | mark<br>mati  | 10             | 19a. Informant's Name/Relationship (Typ  | ee, Print)  | 19b. Mailir                       | ng Address (Street   |                                      | Rural Route Numbe  |  | e. Zin Code)  |
| Š                          | nd 2<br>lith a<br>27 io   |                | Sally Mansfield  | l/Sister  |                                   |  |                                      | urlock,  |  |   |
| ē,                         | s 1 e<br>if Hea<br>item<br>othe   |                | 20a. Method of Disposition   | 20b.  |                                   | sition (Name of<br>natory or other pla                       |                                      | and the same of th | 20c. Location - City                       |   |
| Ĕ                          | Page<br>Tent c<br>Int: if   |                | 1 ☐ Burial 2 1 Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State Mi  | d Sho                             | re Crem  | .Ctr.                                | 12/22/05   | Cambri                                     | dge, MD   |
| Baltimore,                 | permit. Pages 1 end 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel; or iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinet must be notified at ODGe. |                | 21. Signature of Funeral Service License   |   |                                   |  |                                      |  |  |   |
| <u> </u>                   | 8258  |                | 1 Toloule  |   | 2                                 | 16 N. M  | ain St                               | ., Feder   | alsburg                                    | Home, P.A.<br>MD 21632                                  |
|                            |   |                | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one  | cations that caused the dea<br>e cause on each line.                            |                                   |  |                                      |  |  | Approximate<br>Interval Between                         |
| j                          | Physician   |                | Immediate Cause (Final disease or condition  | Corcinor  | na of                             | Vee  | no                                   |  |  | Onset and Death   |
|                            | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as a consec  | quence of                         | 0  |                                      |  |  |   |
| в                          |   | _              | Sequentially list conditions, b.   | Due to (or as a consec  | No account                        |  |                                      |  |  |   |
|                            | ted   | nine           | r any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | D00 10 (01 as a consec  | querica or <sub>j</sub> .         |  |                                      |  |  |   |
|                            | and al-tra  | Examiner       | that initiated events c. resulting in death) Last  | Due to (or as a consec  | quence of):                       |  |                                      |  |  |   |
| 8760,                      | The law requires that the death centificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit  | dical          | 1  |   |                                   |  |                                      |  |  |   |
| 9                          | tificet<br>ng phy<br>as the   | edi            |  |   |                                   |  |                                      |  |  |   |
| Вох                        | eath certific<br>attending p  | In/M           | 230. Was decedent pregnant   | c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Fet                           |                                   | Ectopic pregnance  | ,                                    |  | 23d. Date of                               |   |
| о.<br>О                    | deat<br>de att  | Physician/Med  | in the past 12 months? 1 Pes 2 No  | 4☐ Pregnant at time of o  |                                   | Other (specify)  | ····                                 |  | Month                                      | Day Year  |
| <u>Ч</u>                   | thet the de<br>ned by the a<br>detached f   | Phy            | 9 Unknown  |   |                                   |  |                                      |  |  |   |
| ŝ                          | res th  | Ď              | Part II. Other significant conditions cont   | ributing to death but not re-   | sulting in the u                  | nderlying cause giv  | en in Part I.                        |  |  | s to the cause of death?                                |
| oro                        | w requir<br>been s<br>should  | eted           |  |   |                                   |  |                                      | 1 🗆 Y  |  | Probably 4 Unknown                                      |
| 3ec                        | e iaw<br>has t  | Completed      |  |   |                                   |  |                                      | 24a. Was a autops perfori  | in 24b. Were<br>sy prior<br>med? death     | autopsy findings available<br>to completion of cause of |
| <u>a</u>                   |   |                |  |   |                                   |  |                                      |  | 2 No 1□Y                                   | es 2□ No  |
| ₹                          | Physician:<br>this certifice<br>ral director, I   | Be             | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No  | ospital:  | I EDIO :                          | Oth  |                                      | eath Check only or   |  |   |
| ō                          | Phy<br>r this   | . To           | 27. Manner of Death  | 28a. Date of Injury   | ER/Outpatier<br>28b. Time of      |  | 4 ∐ Nursing<br>y at                  | Home 5 Reside  | ence 6 ∐Other (S<br>ow injury occurred     | pecify)   |
| on                         | Attending is death. ector: After by the funer   | ation          | 1 Matural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year)   | Injury                            |  | k?<br>Yes 2∐No                       |  | . ,  |   |
| Division of Vital Records, | Atte  | tifica         | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of Injury - At h<br>building, etc. (Speci                            | ome, farm, str                    | eet, factory, office   |                                      | 28f. Location (Si<br>City or Town  | treet and Number or                        | Rural Route Number,                                     |
|                            | tel or A  | Certification; |  | building, etc. (Speci   | .,,,                              |  |                                      | City of 10th   | 1, 514(6)                                  |   |
|                            | To the Mospitel or Attending Phwithin 24 hours after death. To the Funarel Director: After th completely filled in by the funeral   | edical         | 29a. Certifier (Check only one)    Certifying Physical Section   C | ician: To the best of my known:  On the basis of examination and manner stated. | owledge, death<br>ation and/or in | n occurred at the tirvestigation, in my o                    | me, date and pla<br>pinion, death oc | ce, and due to the courred at the time, d  | ause(s) and manner<br>ate and place, and o | as stated.<br>due to the cause(s)                       |
|                            | To the within 2 To the complet  | Me             | 29b. Signature and title of certifier  | . 17  |                                   | 29c. Licens  | e number                             | 2  | 9d. Date signed (Mo                        | onth, Day, Year)  |
|                            |   |                | taun =   | Com   | m                                 | Doc  | 14314                                | _  | 12/19/1                                    | 5   |
|                            |   |                | 30. Name and address of person who con   | npleted cause of deat (Ite  | m 23a) (Type,                     | Print)   | 1 1 1                                | 2 1. 1   | 10.4.6                                     | 0.6   |
|                            |   |                |  | LUG · 14:   | S E C                             | enoll 27   | mi, 5                                | Olis Buy   | 110  | 21801   |
| 8                          | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  | 32. Hegistrar's Sign  | Alure                             | 100/21   |                                      | Colis bury.  |  |   |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BESSIE L. ROBINSON DECEMBER 19 2005 11:25PM™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 8279 OLD BLOOMFIELD ROAD EASTON TALBOT 8. Date of Birth Month, Day Year) NOV. 13, 1920 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K) F 85 MARYLAND Director Yrs 213-76-3891 Usual Residence of Decedent death with the Maryland 10a State 10h Counts 10c. City, Town or Location 7 Is marked other than "naturel", or Items 23a or 28e-f show treumatic event, the Madical Examinar must be notified at 10d, Inside City Limits Director 1 ☐ Yes 2 X No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8279 OLD BLOOMFIELD ROAD 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race · American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 should be filed within 72 hours after of and Mental Hyglene.
Is marked other than "naturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 🏋 No 3 Widowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH DAWSON SPENCER LAURA MULLIKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If item 27 Is ALBERT E. ROBINSON/SON 8903 TEAL PT. RD., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit, Page Department of Importent: If eny injury or once. SPRING HILL CEMETERY 12/22/2005 EASTON, MARYLAND ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA JUHN K. MERCERON 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dehydration Enysician I week disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner dementia 10 years Alzheimers Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury burial-transit that initiated events resulting in death) Last Due to (or as a consequence of). attending physician Box 68760 be Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? (es 2 No 1 Yes 1 ☐ Yes 2 ☑No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 ై nathu D52251 30. Name and address of person who completed cause of death [Item 23a], (Type, Print) Easton MID MATTHEW FISCHER MD 2 Martin 1 32. Registrar's Signature State 2 Registrar

|  |               | For<br>State<br>Registrar   | State of Marylar   |                 |                         | nt of H                    |                                       | Mental Hy                              | giene                |                         | 5                       | 42393                               |
|--|---------------|---|--|-----------------|-------------------------|----------------------------|---------------------------------------|--|----------------------|-------------------------|-------------------------|-------------------------------------|
| e e  |               | Decedent's Name (First, Middle, Last)   |  |                 |                         |                            |                                       | 2. Date of D                           | eath                 |                         |                         | 3. Time of Death                    |
| Physicia<br>/Medic   |               | Ruby Alice Ricket   | ts   |                 |                         |                            |                                       | Decemb                                 | er 1                 |                         | еаг<br>05               | 8:15pm <sup>M</sup>                 |
| Examine  |               | 4a. Facility Name (If not institution, give s   |  |                 | 4b. City                | , Town, or                 | Location of Dear                      |  |                      | County of               |                         |                                     |
|  |               | Montgomery Genera   | 1 Hospital   |                 | 01n                     | ey                         |                                       |  |                      | Montg                   | omer                    | v                                   |
| Funeral  | Ev.           | Social Security Number  | 7. Age (In yrs.  | last birthday)  | If Unde                 | or 1 Year<br>Days          | If Under 24 Hrs<br>Hours Min          |  | rth                  |                         |                         | ace (State or Foreign               |
| Director   |               | 416-48-1296   | M 2⊠F 6  | 8 Yrs.          | Wilding                 | Juyo                       | 110013                                | August                                 | 25,1                 | 1937 <i>I</i>           | AL_                     |                                     |
| pu 🔪   | -             | Usual Residence of Decedent  10a. State 10b. County   | 10c Cit  | ty, Town or Lo  | ocation                 |                            |                                       |  |                      |                         | 10                      | d. Inside City Limits               |
| aryla<br>shot  | 7             |   |  |                 |                         |                            |                                       |  |                      |                         | 10                      | 1 ☐ Yes 2 🖾 No                      |
| Ne N   | Director      | Maryland Montgome  10e. Street and Number   | ery  | Gaithe          |                         | rg<br>ip Code              |                                       |  | 10- 04               | izen of Wha             |                         |                                     |
| with   |               |   |  |                 | 101. 2                  |                            | _                                     |  | Tog. Cit             |                         |                         | ry :                                |
| eath   | era           | 101 Odendhal Avenue   | e,# 801<br>12. Was Decedent Ever in U  | C 13 1          | Was Doo                 | 2087                       |                                       | Specify Ves or N                       | 0.                   | USA<br>14. Race -       |                         | n Indian                            |
| be filed within 72 hours after death with the Maryland Ital Hygiere. Id Hygiere: d other than "natural", or Itams 23a or 28e-f ahow avant, ira Medical Exercities is until be ricilited at | by Funeral    | 1 Never Married 2X Married 3 Widowed 4 Divorced   | Armed Forces?  1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:                    |                 | If Yes, sp              |                            | Specify:                              | Specify Yes or N<br>to Rican, etc.)    |                      |                         | White, e                | tc.                                 |
| hou  |               | 15. Decedent's Educ   |  | 16a. Deced      | dent's Us               | ual Occupa                 | tion                                  |  | 16b. Ki              | ind of Busin            |                         |                                     |
| filed within 72 hours at<br>Hygiene.<br>other than "natural", or<br>ant, Ira Medical Exert   | Completed     | (Specify only highest grade   | completed)   | (Give           | kind of w               | ork done d<br>use retired) | uring most of wo                      | orking                                 | 102.74               |                         |                         | 2007                                |
| with<br>liene  | mo            | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                 | C1e                     | rk                         |                                       |  | F                    | Retail                  |                         |                                     |
| filed<br>Hygi<br>other   | BeC           | 17. Father's Name (First, Middle, Last)   |  |                 |                         |                            | 18. Mother's Na                       | me (First, Middle                      |                      |                         |                         |                                     |
| d 2 should be file<br>th and Mental Hy<br>7 la marked oth<br>traumatic avant   | ToB           | John S.   | Clark  |                 |                         |                            |                                       | Mary                                   | E1                   | len.                    | Δ                       | tchlev                              |
| shound M   |               | 19a. Informant's Name/Relationship (Ty)   |  | 19b. Mailir     | ng Addres               | s (Street a                | nd Number or R                        | ural Route Numi                        |                      |                         |                         |                                     |
|  |               | Ervin Eugene Ricket   | tts/Spouse   | 101 0           | dendl                   | hal A                      | venue. ‡                              | 801. Ga                                | ithe                 | rsbur                   | e. M                    | D. 20877                            |
| item<br>item   |               | 20a. Method of Disposition  | 20b. F   | Place of Dispo  | sition (Na              | ame of                     |                                       | Date                                   |                      | ocation - Cit           |                         |                                     |
| permit. Pages 1 ar<br>Depertment of Hea<br>mportant; if Itam;<br>my injury or other  |               | 1 ☐ Burial 2 🖾 Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)                              | emoval from State  |                 | -                       |                            | 1                                     | /14/05                                 | Δ1e <sup>-</sup>     | xandr:                  | ia.                     | Virginia                            |
| orta<br>inju   | ı             | 21. Signature of Funeral Service License  |  |                 |                         |                            |                                       | eVol Fu                                |                      |                         |                         | virginia                            |
| Page 1   |               | Vole + X(4)   | NA   | -               |                         |                            |                                       | Dr., Ga:                               |                      |                         |                         | 20877                               |
| 12/2   |               | 23a. Part1. Epter the disease, or compli  | cations that ceused the deat   |                 |                         |                            |                                       |  |                      | SDULE                   |                         | Approximate                         |
| m  |               | shock, or heart failure. List only or<br>Immediate Cause (Final                                 |  |                 |                         |                            |                                       |  |                      |                         |                         | Interval Between<br>Onset and Death |
| Physician -<br>/Medical  |               | disease or condition resulting in death)  | Sepsis  Due to (or as a conseq   | mence of):      |                         |                            |                                       |  |                      |                         | - 2                     | 2 days                              |
| Examiner   |               |   | 540 10 (01 43 4 0011300  | juditiod of j.  |                         |                            |                                       |  |                      |                         |                         |                                     |
| *  | ē             | Sequentially list conditions, if any, leading to immediate                                      | Due to (or as a conseq   | juence of):     |                         |                            |                                       |  |                      |                         |                         |                                     |
| d<br>ansit   | Examiner      | cause. Enter Underlying Cause (Disease or injury that initiated events                          |  |                 |                         |                            |                                       |  |                      |                         |                         |                                     |
| execuna and and and and and and and and and a  | Exa           | resulting in death) Last  | Due to (or as a conseq   | uence of):      |                         |                            |                                       |  |                      |                         |                         |                                     |
| cate be executed<br>physicien and<br>the burial-transit  | dical         |   | . —  |                 |                         |                            |                                       |  |                      |                         |                         |                                     |
| tifical<br>g phy<br>as th  | a ·           |   |  |                 |                         |                            |                                       |  |                      |                         |                         |                                     |
| law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit                                       | lan/M         | Zob. Was decedent pregnant  | 3c. If yes, outcome of pregna<br>1 ☐ Live birth 2 ☐ Feta                     |                 | Testacia                | oregnancy                  |                                       |  |                      | 23d. Date o             | f deliver               | у                                   |
| he death cerr<br>the attendin  | Cla           | in the past 12 months?<br>1 ☐ Yes 2 ☒ No  | 4☐Pregnant at time of c  |                 | Dectopic in Other (s    |                            |                                       |  |                      | Month                   |                         | Day Year                            |
| by the detached  | Physicia      | 9 🗆 Unknown   | 9 Unknown  |                 |                         |                            |                                       |  |                      |                         |                         |                                     |
| res that<br>igned b  | by P          | Part II. Other significant conditions con   | tributing to death but not res   | ulting in the u | nderlying               | cause give                 | n in Part I.                          | 23e. Did                               | tobacco u            | ise contribu            | ite to the              | cause of death?                     |
| w require<br>been sig<br>should b  | ed            |   |  |                 |                         |                            |                                       | 1 🗆                                    | Yes 2                | □ No 3[                 | ] Proba                 | bly 4 Munknown                      |
| he law requires t<br>s has been signe<br>ge 2 should be o  | Completed     |   |  |                 |                         |                            |                                       | 24a. Wa                                |                      | 24b. Wei                | re autop                | sy findings available               |
| The la   | Eo            |   |  |                 |                         |                            |                                       |  | ormed?               | prio                    | r to com                | pletion of cause of                 |
| stcien; The law<br>certificate has l<br>irector, page 2 s  | 0             | 25. Was case referred to medical  |  |                 |                         |                            | 26. Place of De                       | 1 ☐ Yes<br>ath (Check only             |                      | 1 10                    | 185 2                   | I I IVO                             |
|  | 0             | examiner?<br>1 ☐ Yes 2X No  | ospital: 1 🖾 Inpatient 2 🗆   | ER/Outpatien    | nt 3 🗆 🗅                | Othe                       |                                       | dome 5 Res                             |                      | 6 Other                 | Specify                 |                                     |
| l or Attending Phy<br>after death.<br>Director: After this<br>in by the funeral d  | L L           | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)                                     | 28b. Time of    |                         | 28c. Injury<br>Work        |                                       | 28d. Describe                          |                      |                         | 001.3/                  |                                     |
| or Attending iffer death.  Director: After in by the funer   | atlo          | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investigation   | (WOILII, Day 19af)   | Injury          | м                       |                            | es 2 □ No                             |  |                      |                         |                         |                                     |
| after death<br>Director:<br>d in by the  | E C           | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At h  | ome, farm, str  | eet, facto              | ry, office                 |                                       | 28f. Location                          | Street an            | d Number                | or Rural                | Route Number,                       |
| ppltel or<br>ours afte<br>nerel Dir<br>filled in t   | Certification | 7 LI HOHIOUG  | building, etc. (Specif   | 7/              |                         |                            |                                       | City or 10                             | wп, State            | ,                       |                         |                                     |
| A Hospi<br>24 hou<br>Funer<br>etely fill   | Medical (     | 29a. Certifier 1 Certifying Physical Const. (Circle Conf.) 2 Medical Examination (Circle Conf.) | sician: To the best of my knoner: On the basis of examina and manner stated. | owledge, death  | n occurre<br>vestigatio | d at the time              | e, date and place<br>inion, death occ | e, and due to the<br>urred at the time | cause(s)<br>date and | and manne<br>place, and | er as sta<br>I due to t | ted.<br>the cause(s)                |
| To the within To the compl   | Me            | 29b. Signature and title of certifier   | /  | ,               | 25                      | c. License                 | number                                |  | 29d. Dat             | e signed (A             | Aonth, D                | ay, Year)                           |
| 3  | 1             |   |  |                 |                         | D 04                       | 51681                                 |  | Deco                 | ember                   | 1 /4                    | 2005                                |
|  | 7             | 30. Name and address of person who co   | mpleted cause of death (Item   | n 23a) (Tyne    | Print)                  | ט ע                        | 1001                                  |  | ресе                 | mber                    | 14,                     | 2005                                |
|  |               | Robert Kirkaldy, M.   |  |                 | ,                       | Dr.                        | # 210-                                | Olnev.                                 | Mary                 | land                    | 208                     | 32                                  |
| Stat   |               | 31. Date filed (Month, Day, Year)   | A. Registrar's Signa   | ature           | M. B                    | ,                          |                                       |  |                      | ,u                      |                         | -                                   |
| Registra   |               | DEC 15 2009   | Registrar's Signa  | A               |                         |                            |                                       |  |                      |                         |                         |                                     |

|                   |   |                | 1 = For<br>State<br>Registrar   | State of I  | Marylan                        |   | artmen<br>rtificate                     |                         |                                 |                        |                                       | Reg. No.                | 05   | 42394  |
|-------------------|---|----------------|---|---|--------------------------------|---|---|-------------------------|---------------------------------|------------------------|---------------------------------------|-------------------------|--|--|
|                   | Physici<br>/Medic   | _              | 1. Decedent's Name (First, Middle, La<br>Clinton Ottobier   | ,   | III                            |   |   |                         |                                 |                        | 2. Date of De<br>Month                | Day                     | Year (2005                                 | 3. Time of Death   |
|                   | Examir  |                | 4a. Facility Name (If not institution, give Washington Count  |   |                                |   |   |                         | Location of                     |                        |                                       |                         | nty of Death<br>hingto                     | on   |
|                   | Funeral<br>Director   |                | 5. Social Security Number 6. S 220–18–2096  | ex 7.<br>☑M 2□F   | Age (In yrs.                   | last birthday)<br>Yrs.                      | If Under<br>Months                      | 1 Year<br>Days          | If Under:<br>Hours              | 24 Hrs.<br>Min.        | 8. Date of Bir (Month, Da 08/18/      | th<br>19, Year)<br>1929 | 9. Birthp<br>Cour                          | place (State or Foreign<br>htry) MD                      |
|                   | D   |                | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. Cit                       | y, Town or Lo                               | cation                                  |                         |                                 |                        | 00/20/                                |                         | 1  | Od. Inside City Limits                                   |
|                   | he Mary<br>28a-f sh<br>otified  | Director       | MD Washingt   | on  | Hag                            | gerstow                                     | n<br>10f. Zip                           | Code                    |                                 |                        |                                       | 10g. Citizen            | -4 \A/b = 4 Co                             | 1 XYes 2 □ No  |
|                   | 23a or  | ral Dir        | 45 Sunbrook Lane  |   |                                |   | 217                                     | 742                     |                                 |                        |                                       | US                      |  |  |
| 980               | d within 72 hours after death with the Maryland<br>jiene.<br>rithan "natural", or Items 23a or 28s-1 show<br>the Madical Exempler must be notified at | by Funeral     | 11. Marital Status 1 □ Never Married 212 Married 3 □ Widowed 4 □ Divorced   | 12. Was Decede<br>Armed Force<br>1 X Yes 2[<br>If Yes, Give<br>Year or Date | s?<br>⊒ No                     | 1   | Was Deced<br>f Yes, spec<br>1 ☐ Yes 2   |                         | spanic Origin, Mexican Specify: | gin? (Spi<br>i, Puerto | ecify Yes or No<br>Rican, etc.)       | Spe                     | lace - Americ<br>Black, White,<br>cify: Wh |  |
| 21215-0036        | n "natu<br>Madical  | Completed      | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | de completed)   | v. 6. \                        | 16a. Deced<br>(Give<br>life.                | dent's Usua<br>kind of wor<br>DO NOT us | k done d                | uring most                      | t of work              | ng                                    | 16b. Kind of            | Business/In                                | dustry   |
|                   | be filed within tal Hygiene. d other than "event, the Mac   |                | 12 17. Father's Name (First, Middle, Last,  | College (1-40   | JI 5+1                         | Ele   | ectro-                                  | mech                    |                                 | r's Name               | (First, Middle,                       |                         | ce Mac                                     | chines   |
| Maryland          | \$ 6 5 V  | To Be          | Clinton Ottobier  | n Rowland   | , Jr.                          |   |   |                         | Edna                            | a El                   | izabeth                               | Paynt                   | er   |  |
|                   | 12 s<br>h ar<br>7 is<br>trau  |                | 19a. Informant's Name/Relationship ( Shirley A. Rowla   |   |                                | 45 8  | Sunbro                                  | ok I                    | Lane,                           |                        | erstown                               |                         |  | Code)  |
| Baltimore,        | 0 to 1  |                | 20a. Method of Disposition  1 ★ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif  |   | re :                           | Place of Dispo<br>cometery, crer<br>St Have |   |                         |                                 |                        | /2005                                 |                         | n - City or To                             |  |
| Balti             | permit. Pag<br>Department<br>Important: I<br>any injury o   |                | 21. Sir pature of Funeral Service Line  | Semu  | in                             | 30  | . Name and                              | d Address               | s of Facility                   | y Ge                   |                                       | Minni                   | ch Fur                                     | neral Home   |
| *                 | Physician   |                | 23a. Part 1. Enter the disease, or com<br>shock or heart failure. List only<br>Immediate cause (Final                             | one cause on each   | an C                           |   | er the mode                             |                         |                                 |                        | or respiratory ai                     |                         |  | Approximate<br>Interval Between<br>Onset and Death       |
|                   | /Medical<br>Examiner  |                | disease or condition resulting in death)  | Due to (or  | as a conseq                    | - 1   | Large                                   | trus                    | · Cu                            | . 62                   | disce                                 |                         |  |  |
|                   | Sit 8d  | lner           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or   | as a conseq                    | uence of):                                  | 2-11                                    |                         |                                 | 7                      | or per                                | 4                       |  | , , , , , , , , , , , , , , , , , , ,                    |
| 8760,             | ite be executed<br>lysician and<br>ne burial-transit  | Ical Examiner  | that initiated events<br>resulting in death) Last   |   | asla conseq                    |   | trea                                    | st                      | fri!                            | Cur                    |                                       |                         |  |  |
| P.O. Box 68       | at the death certifical<br>by the ettending phi<br>tached for use as th   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcor<br>1 Live birth<br>4 Pregnant<br>9 Unknowr              | 2 ☐ Feta<br>at time of d       | Ideath 3                                    | Ectopic pre                             |                         |                                 |                        |                                       |                         | Date of delive                             | ary<br>Day Year  |
|                   | signed<br>d be de   | by             | Part II. Other significant conditions of  | Fibra 1   | la tre                         | en  | nderlying ca                            | ause give               | n in Part I.                    |                        |                                       |                         |  | ne cause of death?                                       |
| of Vital Records, |   | Completed      | (Drabe fre  | g me  | llita                          | 4   |   |                         |                                 |                        | 24a. Was<br>autop<br>perfo<br>1 🗆 Yes | rmed?                   | prior to cor<br>death?                     | psy findings available<br>inpletion of cause of<br>20 No |
| f Vita            | Physician: Th<br>this certificate<br>ral director, pag  | To Be          | 25. Was case referred to medical examiner?  1  Yes 2  | Hospital: 1   | atient 2 🗆                     | ER/Outpatien                                | t 3 DO.                                 | A Othe                  | ~                               |                        | n <i>(Ch</i> eck only o               |                         | ther (Specify                              | v)   |
|                   | ding<br>After<br>tune   |                | 27. Manner Death 1 Natural 5 Pending 2 Accident investigation   |   | njury<br>Day Year)             | 28b. Time of<br>Injury                      | M 28                                    | Bc. Injury<br>Work      | at<br>?<br>'es 2 □ h            |                        | 28d. Describe h                       | now injury occ          | urred                                      |  |
| Division          | i Dife  | Certification: | 3 Suicide 6 Could not b determined  | 289. Place of   | Injury - At he<br>etc. (Specif | ome, farm, str                              | eet, factory,                           | , office                |                                 |                        | 28f. Location (S<br>City or Tow       |                         | mber or Rura                               | l Route Number,  |
|                   | Hospital     24 hours     Funeral letely filled   | edical         | 29a. Certifier 1 Certifying Ph  | ysician: To the be<br>niner: On the basis<br>and manner                     | of examina                     | wiedge, death<br>ition and/or inv           | occurred a<br>vestigation,              | at the time<br>in my op | e, date and<br>inion, deat      | d place, a             | and due to the o                      | cause(s) and i          | manner as st<br>e, and due to              | ated.<br>the cause(s)                                    |
|                   | To th<br>withir<br>To th<br>comp  | Σ              | 29b. Signature and atte of certifier  | C   | <u> </u>                       | M. O  |   | License                 |                                 | 21                     |                                       | 29d. Date sign          | ned (Month,                                | Day, Year)   |
| Air               |   |                | 30. Name an inddress of perior who  | completed cause of  | death (Item                    | 23a) (Type,                                 | Print)                                  | EP                      | -7 L                            | ٠. ٥                   | OFFE                                  | æ5 i                    | in. t                                      | 5.   |
| H                 | - 5+  <br>≤ ≤ Sta   |                | 31. Date filed (Month, Day, Year)   | 32. Regi  | strar's Signa                  | Itaq  | 215 fo                                  | wh                      | 1                               | ND                     | 21                                    | 140                     |  |  |
|                   | Registr   | ar             | DEC 19 2  | 1005  | eu .                           | D. 19                                       | wie                                     |                         |                                 |                        |                                       |                         |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Willtam Rounsles 12 1355 2005 /Medical 4a. Fecility Name (If not institution, give street and humber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Soutobary Hospital MD Wicomico Head Deers If Under 1 Year | M Under 24 Hrs. 6. Sex 14 M 2 ☐ F 8. Date of Birth (Month, Day, Yeer) 08-01-1931 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 74 Director 206-24-7604 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County , or items 23a or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Wicomico Directo Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 31091 Mt. Herman Rd 21805 US death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Y☐Yes ≥ ☐ No If Yes, Give Year or Dates: 1950-54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11 Marital Status filed within 72 hours after 1 Never Married Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ Specify: white 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) Methodist Church Minister permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: if Item 27 ie marked other th any injury or other traumatic event, this once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William A. Rounsley Ruth I. Jacobson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Rounsley - wife 31091 Mt. Herman Rd, Salisbury, MD 21805 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State Odd Fellows Cemetery 12/17/05 Seaford, DE \* 4 ☐ Donation 7 5 ☐ Other (Specify) 21. Signature of Emeral Convice Lizensee 22. Name and Address of Facility
Cranston Funeral Home John A. Cranston P O Box 967, Seaford, DE 19973

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attanding Physician: The law requires that the death certificate be executed thrive ai luse to Due to (or as a consequence of): Box 68760, attending physician disease Physician/Medical stage IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Valursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death
1 Natural
2 Accident 28b. Time of Injury 28d. Describe how injury occurred After t 5 Pending 1 ☐ Yes 2 ☐ No death J Director: A investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Center Salibly HYUN Deer 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 1 5 2005 Registrar

LONNIE LEE RASH, UNK 05-8554 AKG

or Print in Black Indelible Ink Ensure All Copies Are Legible

| rend Unpend item#1, 23a,27,28a-f,pen/E,C851, 1/26/06 TT<br>State of Maryland / Department of Health and Mental Hygiene 05 | 2396 |
|---|------|
| State of Maryland / Department of Health and Mental Hygiene   | 2396 |
| end Unnend item#1. 23a.27.28a-f.perME.G851.T/26/06.TT   | 2000 |

Physic /Medi Examir

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 23a or 28a-1 ehow eny injury or other treumatic event, the Madical Examinational Examinational angose.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

|                     | 1 - Stata<br>Ragistrar  |   |                                     | Certific   | ate of L                                 | Death                                |                      |   | Reg. No.                       |                                      |  |  |
|---------------------|---|---|-------------------------------------|--|--|--------------------------------------|----------------------|---|--------------------------------|--------------------------------------|--|--|
| an                  | Decedent's Name (First, Middle  | _ ,   |                                     |  |  |                                      |                      | <ol><li>Date of Dea<br/>Month</li></ol>     | Day                            | Year                                 | 3. Time of Dear                                    |  |
| cal                 |   | ee Rash   |                                     |  |  | · CW                                 |                      | Decembe                                     | ,                              | 2005                                 | 11:17 A  |  |
| ner                 | 4a. Facility Name (If not institution bods behind Youths  |   |                                     | ol Fa  | City, Town, or<br>111stor                | 1                                    |                      |   |                                | ford                                 |  |  |
|                     | 5. Social Security Number 219-17-0130   | 6. Sex 7. Ag  | ge (In yrs. last bli<br>19          | Yrs. If U  | nder 1 Year<br>ths Days                  | If Under<br>Hours                    | Min.                 | 8. Date of Birtl<br>(Month, Day<br>Dec • 27 | 1985                           | Cou                                  | place (State or Foi<br>Intry)<br>/Land             |  |
|                     | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Tow                      | vn or Location   |  | -                                    |                      |   |                                |                                      | 10d. Inside City Li                                |  |
| ō                   |   |   |                                     |  |  |                                      |                      |   |                                | 1 □ Yes 2 €                          |  |  |
| ect                 | Maryland Harford Bel Ail  |   |                                     |  | 10f. Zip Code                            |                                      |                      |   | 10g. Citizen of What Country?  |                                      |  |  |
| ā                   | 2236 Thomas Run Road  |   |                                     |  | 21015                                    |                                      |                      |   | USA                            |                                      |  |  |
| by Funeral Director | 11. Marital Status  1 ☑ Never Married 2 ☐ Mari 3 ☐ Widowed 4 ☐ Divorced   | 12. Was Decedent<br>Armed Forces'<br>1 ☐ Yes 2 ☐<br>If Yes, Give        | ?                                   | If Yes,  | ecedent of Hi<br>specify Cuba<br>es 2 No | spanic Ori<br>n, Mexicar<br>Specify: | n, Puerto A          | cify Yes or No-<br>lican, etc.)             | BI                             | ice - Amer<br>ack, White<br>ify: Whi |  |  |
| Completed           | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  |   |                                     | Decedent's Usual Occupation<br>(Give kind of work done during most of working<br>life. DO NOT use retired) |  |                                      |                      | g   | 16b. Kind of Business/Industry |                                      |  |  |
| E                   | 12  | College (1-40)  | 37,                                 | Cook   |  |                                      |                      |   | Resta                          | urant                                | <u> </u>   |  |
| Bec                 | 17. Father's Name (First, Middle,   |   |                                     |  |  | _                                    |                      | (First, Middle,                             |                                |                                      |  |  |
| 2                   | Lonnie Lee  | Rash Sr.  |                                     |  |  | Joan                                 |                      |   | ornwell                        |                                      |  |  |
|                     | 19a. Informant's Name/Relations Lonnie Lee Rash   |   |                                     |  |  |                                      |                      | , Bel A                                     |                                |                                      |  |  |
|                     | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S   |   | cemete                              | of Disposition<br>ary, crematory<br>COP Ser  | or other place                           |                                      | Da<br>12 <b>–</b> 24 | -2005                                       | 20c. Location                  | · City or T                          |  |  |
|                     | 21. Signature of Funeral Service  | Licensee  |                                     | 22. Nam<br>McCC  | e and Address<br>mas Fu<br>Cokes         | s of Facili<br>inera<br>sbury        | I Hom<br>Road        | e, P.A.                                     | jdon, M                        | D 2:                                 | 1009   |  |
| ē                   | 23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate | a. Hanging Due to (or as  | a consequence                       | of):   | mode of dying                            | g, 30011 <b>a</b> 3                  | Cardiac or           | төзриштогу ши                               | 631,                           |                                      | Approximate<br>Interval Betweer<br>Onset and Death |  |
| dicai Examin        | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | с   | a consequence                       |  |  |                                      |                      |   |                                |                                      |  |  |
| by Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 Fetal death                       |  | ic pregnancy<br>r (specify)              |                                      |                      |   |                                | ate of delivionth                    | very<br>Day Year                                   |  |
|                     | Part II. Other significant condition  | ons contributing to death I   | out not resulting i                 | in the underly   | ng cause give                            | n in Part I                          |                      | 23e. Did to                                 | ند.                            | ntnbute to                           | the cause of death<br>bably 4 ∏Unkn                |  |
| Completed           |   |   |                                     |  |  |                                      |                      | 24a. Was a<br>autop<br>perfor<br>1 1 Yes    | sy                             | prior to co                          | opsy findings avail<br>ompletion of cause          |  |
| Be (                | 25. Was case referred to medica examiner?   |   |                                     |  | To.                                      |                                      |                      | Check only or                               |                                |                                      |  |  |
| မ                   | 1 X Yes 2 No<br>27. Manner of Death   | Hospital: 1 Inpati  | ury FTC 28b.                        | utpatient 30   | 28c. Injury                              | at                                   |                      | e 5 🗌 Resid<br>3d. Describe h               |                                |                                      | wat scen   |  |
| tioi                | 1 Natural 5 Pendir<br>2 Accident investi  | ng (Month, Da   | y Year)                             | :17 A M  | Work                                     | ?<br>∕es 2 <b>X</b> ∑                | No                   | Subject                                     | Han od o                       | o1f                                  |  |  |
| Certification:      | 3/2 Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | not be 28e. Place of In   | jury - At home, fa<br>tc. (Specify) |  | ctory, office                            |                                      | 2                    | Bf. Location (S<br>City or Tow              | treet and Num<br>n, State) WO  | ods Be                               | hind Youth<br>1 Fallston                           |  |
| Medical C           |   | ng Physician: To the best<br>Examiner: On the basis of<br>and manner st | of examination ar                   |  |  |                                      | nd place, ar         | nd due to the d                             | ause(s) and n                  | anner as :                           | stated.  |  |
| Me                  | 29b. Signature and title of certifie  | or .  |                                     |  | 29c. License                             | number                               | _                    | 1   | 29d. Date sign                 | ed (Month,                           | Day, Year)   |  |
|                     | Hanch Brish   | ruff nes  | double (Non- 20 )                   | (True Siri   | 0.C.1                                    | 1.E.                                 |                      | I   | Decembe                        | r 19,                                | , 2005   |  |
|                     | 30. Name and address of person  | who completed cause of  | geath (Item 23a)                    | (Type, Print)  |  |                                      |                      |   |                                |                                      |  |  |
| ate                 | Prince E Southa<br>31. Date filed (Month, Day, Year)  | U, MO   |                                     | ll Penr  |  | et, B                                | altim                | ore, Ma                                     | aryland                        | 212                                  | 201  |  |

DHMH 17 Rev 1/2001

Registrar

DEC 3 0 2005

|                            |   |                  | 1 - For<br>State<br>Registrar   |                                 | State of M                                       | larylan           | d / Depa<br><i>Cei</i> | artment<br>rtificate        | t of H                  | ealth a     | and M         |  | Emak        | 005                             | 42:                                    | 398                  |
|----------------------------|---|------------------|---|---------------------------------|--|-------------------|------------------------|-----------------------------|-------------------------|-------------|---------------|--|-------------|---------------------------------|--|----------------------|
|                            | Dhamis  |                  | 1. Decedent's Name (I   |                                 | ,  |                   |                        |                             |                         |             |               | 2. Date of Dea                             |             |                                 | 3. Time of                             | of Death             |
|                            | Physic<br>/Medi   |                  | Clark   | Fredri                          | ck Reide   | <b>≥</b> 1        |                        |                             |                         |             |               | December December                          | er 21       | Year<br>. 200                   |  | O A <sup>M</sup>     |
|                            | Exami   | ner              | 4a. Facility Name (If no  |                                 |  |                   |                        | 4b. City, 7                 | Town, or                | Location o  | f Death       |  | 4c. C       | ounty of Dea                    |  | <u> </u>             |
|                            | *   |                  | I-83 south,<br>5. Social Security Num   | , south                         |  |                   |                        |                             |                         | Hil]        |               |  |             | Bal                             | timore                                 |                      |
| R                          | Funeral<br>Director   |                  | 535-80-4  |                                 | X<br>M 2□F 7. A                                  | 35                | ast birthday)<br>Yrs.  | If Under<br>Months          | Days                    | If Under a  | Min.          | 8. Date of Birth<br>(Month, Day<br>Jan. 29 | Year)       | 9. Bi                           | rthplace (State<br>country)<br>nnsylva | or Foreign           |
|                            | P .   |                  | Usual Residence of De   |                                 |  |                   |                        |                             |                         |             |               |  | , 10        | O FC                            | ımısyıva                               | шта                  |
|                            | anylar<br>ehow  | 2                |   | 0b. County                      |  | 10c. City         | , Town or Lo           | cation                      |                         |             |               |  |             |                                 | 10d. Inside C                          |                      |
|                            | the M   | ecto             | PA  10e. Street and Number  | York                            |  | Dov               | er                     | 101.71                      |                         |             |               |  |             | ·                               |  | s 22 No              |
|                            | 72 hours after death with the Maryland<br>"natural", or Iteme 23a or 28a-f show<br>sideal Examinating the motified at                       | Funeral Director | 5551 Pi   |                                 | l Road   |                   |                        | 10f. Zip (                  | .731                    | 5           |               |  |             | en of What C                    | ountry?                                |                      |
|                            |   | Iner             | 11. Marital Status  |                                 | 12. Was Decedent<br>Armed Forces?                | Ever in U.S       |                        | Vas Decede<br>Yes, speci    | ent of His              | spanic Orig | pin? (Spec    | city Yes or No-                            |             | . Race - Am                     | erican Indian,                         |                      |
| 36                         | within 72 hours after<br>sne<br>then "natural", or Ite<br>he Medical Exertical  | by F.            | 1 X Never Married<br>3 ☐ Widowed 4 ☐  |                                 | 1 ☐ Yes 2X<br>If Yes, Give<br>Year or Dates:     | No                |                        | Yes 2                       |                         | Specify:    | , i dono i    | ncan, etc.)                                | s           | Black, Whi<br>pec <i>ify:</i> V | te, etc.<br>Thite                      |                      |
| 21215-0036                 | 2 hou   | ted              | 15  | . Decedent's Edu                | cation   |                   | 16a. Deced             | lent's Usual                | I Occupa                | tion        |               |  |             | of Business                     |  |                      |
| 218                        | thin 7  | Completed        | (Specify (<br>Elementary/Seconda  | only highest grad<br>ary (0-12) | (e completed) College (1-4or                     | 5+)               | (Give<br>life. L       | kind of work<br>OO NOT use  | k done di<br>e retired) | uring most  |               | 9  | 100. 10110  | or Dusiness                     | viridustry                             |                      |
|                            | filed w<br>Hygier<br>other th   | Co               | 12  | 1.16.17                         |  |                   | Mach:                  | ine P                       |                         |             |               |  |             |                                 | chinery                                | Y                    |
| Maryland                   | d a b   | Be C             | 17. Father's Name (Fire   |                                 | Reidel   |                   |                        |                             |                         |             |               | <i>(First, Middle, I</i><br>Jean F         |             |                                 |  |                      |
| JZ.                        | should<br>nd Men<br>marke   | 2                | 19a. Informant's Name   | A/Relationship (T)              | rpe, Print)                                      |                   | 19b. Mailin            | a Address /                 | (Street a               |             |               | Route Number                               |             |                                 | 7:- 0- 4-)                             |                      |
| _                          | and 2<br>lealth a<br>m 27 le  |                  | Betty Jea   |                                 |  | her               | 555                    | l Pi                        | ne l                    | Hill        | Rd.           | , Dove                                     | er,         | PA 17                           | 7315                                   |                      |
| ore                        | of He   |                  | 20a. Method of Disposi  | ition                           | lemoval from State                               | 20b. Pla          | ace of Dispos          | sition (Name                | e of                    |             | Da            | ite  |             |                                 | Town, State                            |                      |
| Baltimore                  | Pages<br>tment of it<br>tent: If its<br>jury or o   | 95               | 4 Donation 5  | Other (Specify)                 |  | Cre               | matic                  | on Se:                      | rvic                    | ce !        | ec. 2<br>2005 |  |             |                                 | 17404                                  |                      |
| Bal                        | permit. Pages 1 ar<br>Department of Hea<br>Important: If Item<br>any injury or othe   |                  | 21. Signature of Funer  | War                             | tenste   | ×n                | 2                      | 4 Se                        | con                     | d St        | ., N          | . Harte<br>lew Fre                         | edoi        | in Mo<br>m, PA                  | ortuary<br>17349                       | y,Inc.               |
|                            |   |                  |   | indio. List offiny of           | ications that caused<br>ne cause on each ti      | the death.<br>ne. | Do not ente            | r the mode                  | of dying,               | such as c   | ardiac or     | respiratory arre                           | est,        |                                 | Approximat<br>Interval Bet             | te<br>ween           |
|                            | Physician /Medical  |                  | Immediate Cause (Fina<br>disease or condition<br>resulting in death)                                | al 🕳 â                          | . Mult   | ple in            | y2019                  | es                          |                         |             |               |  |             |                                 | Onset and I                            | Death                |
|                            | Examiner  |                  |   |                                 | Due to (or as                                    | a conseque        | erice of):             |                             |                         |             |               |  |             |                                 |  |                      |
|                            | 7 ~   | ner              | Sequentially list conditi   | ions, diale                     | Oue to (or as                                    | a nor seque       | anca of):              |                             | _                       |             |               |  |             |                                 |  |                      |
| V                          | acuted<br>ind<br>transi   | Examiner         | cause. Enter Underlyin<br>Cause (Disease or injurithat initiated events<br>resulting in death) Last |                                 | )  |                   |                        |                             |                         |             |               |  |             |                                 |  |                      |
| 60,                        | cate be executed<br>physicien and<br>the burial-transit   | al Ex            | resulting in Ceatin) Last   |                                 | Due to (or as                                    | a conseque        | ence of):              |                             |                         |             |               |  |             |                                 |  |                      |
| 68760,                     | ificate be executed<br>g physicien and<br>as the burial-transIt   | edical           |   |                                 | !. <u></u>                                       |                   |                        |                             |                         |             |               |  |             |                                 |  |                      |
| Вох                        |   | M/U              | IF FEMALE:<br>23b. Was decedent pre   | egnant 2                        | 3c. If yes, outcome                              | of pregnan        |                        |                             |                         |             |               |  | 23d         | . Date of del                   | iven                                   |                      |
|                            | requires that the death cert<br>een signed by the attendin<br>hould be detached for use   | Physician/M      | in the past 12 mor  |                                 | 1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown |                   |                        | Ectopic preg<br>Other (spec |                         |             |               |  |             | Month                           |  | /ear                 |
| P.0                        | that the de<br>ed by the<br>detached  |                  | 9 Unknown   | at conditions                   |  |                   |                        |                             |                         |             |               | 1  |             |                                 |  |                      |
| Division of Vital Records, | signe<br>d be d   | 9                | Part II. Other significan   | it conditions con               | tributing to death bi                            | ut not result     | ling in the und        | derlying cau                | ise given               | in Part I.  |               |  |             | ,                               | the cause of d                         |                      |
| CO                         | ≥ 0 0 l   | lete             |   |                                 |  |                   |                        |                             |                         |             | _             | 1 ☐ Ye                                     | -3          |                                 | obably 4 🗍 U                           |                      |
| Re                         | 0 - 0   | Completed        |   |                                 |  |                   |                        |                             |                         |             |               | 24a. Was ar<br>autopsy<br>perform          | ed?         | 4b. Were au<br>prior to death?  | topsy findings a<br>completion of ca   | available<br>ause of |
| ita                        | ilclan: Th<br>certificete<br>rector, pag  | BeC              | 25. Was case referred t   | to medical                      |  |                   |                        |                             |                         | P6 Place o  | f Death A     | 1 Pes 2<br>Check only one                  | □ No        | 12 Yes                          | 2□ No                                  |                      |
| <u>&gt;</u>                | S 5   | To               | examiner?<br>1∭ Yes 2 ☐ No  | Н                               | ospital:   | nt 2 🗆 El         | R/Outpatient           | 3□ DOA                      | 1 04                    |             |               | 5 🗆 Resider                                |             | Other (Snec                     | (fy) SCEN                              |                      |
| č                          | ing P   |                  | 27. Manner of Death 1 □ Natural 5   | ☐ Pending                       | 28a. Date of Injur<br>(Month, Day                |                   | 8b. Time of            | 280                         | : Injury a<br>Work?     | ıt          | 28            | d. Describe ho                             | w injury oc | curred                          | 3024                                   |                      |
| isi                        | Attending<br>ir death.<br>ector: Atter<br>by the fune   | cat              | 2.  Accident<br>3  Suicide 6  | investigation  Could not be     | Dec 21,200                                       | 5 6               | 0140 A                 | M                           | 1 🗌 Ye                  | s 2 📉 No    |               | liver of                                   |             |                                 |  | -                    |
| ĕ                          | ll or A<br>efter<br>Direct  | Certification:   | 4 Homicide  | determined                      | 28e. Place of Inju-<br>building, etc             | . (Specity)       |                        | et, factory, o              | office                  |             |               | Location (Str.<br>City or Town,            | State)      |                                 |  | ber.                 |
|                            | Hospital or 24 hours efte     Funeral Directory filled in 1914  |                  | 29a. Certifier 1  | Certifying Phys                 | ician: To the best of                            | f my knowl        | edge, death            | occurred at                 | the time.               | date and    | -1            | 83 Soft                                    |             | Dane, Pro-                      | 016 11/10                              | 4 MD                 |
|                            | To the Hospital or Attending Ph<br>within 24 hours elter death.<br>To the Funeral Director: Atter th<br>completely filled in by the funeral | edicai           | (Check only 2X)   | Medical Examin                  | er: On the basis of<br>and manner sta            | Granmiano         | n and/or inve          | stigation, in               | my opin                 | ion, death  | occurred      | at the time, da                            | te and pla  | ce, and due                     | to the cause(s)                        |                      |
|                            | To the within 2 To the complet  | Σ                | 29b. Signature and title  | of certifier                    | 0  |                   |                        | 29c. L                      | icense n                | number      |               | 29   | d. Date si  | gned (Month                     | , Day, Year)                           |                      |
| 7                          |   |                  | Join  | as d                            | ee 1   | us                |                        |                             | 0.0                     | .м.Е.       |               | De   | ecemb       | er 21,                          | 2005                                   |                      |
|                            | 10  |                  | 30. Name and address of   |                                 | mpleted cabse of de                              | ath (Item 2       |                        |                             | troo                    | t Da        | 1+-1          | ore, Ma                                    |             | nd 010                          | 201                                    |                      |
|                            | Stat  | е                | 31. Date filed (Month, Di   |                                 | 32 Registra                                      | r's Signatur      |                        | CILL D                      | CTCC                    | . с, пс     | 41 L 111      | ore, He                                    | ır yıd      | 110 212                         | OT                                     |                      |
|                            | Registra  | ir               | DEC   | 3 0 200                         | 5 Garage   | , Jr.             | 603                    |                             |                         |             |               |  |             |                                 |  |                      |

State of Maryland / Department of Health and Mental Hygiene 42399 Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November 25, 2005 **Physician** 00:30 a M John C. Reid Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesua

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Aug. 16, 1952 | 9. Birthplace (Country)

Washington, DC Montgomery Suburban Hospital 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2 ☐ F 578-70-2959 Yrs. 53 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Eventiant moust be notified at once. 10a State 10b County YE Yes 2 No Director Washington DC. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** apt 303 20020 1528 Butler Street SE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 X Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Unknown IInknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Cora Unknown Charles Reid 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1528 Butler Street SE apt 303 Wash, DC 20020 Deserhie Henson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Dec.2,2005 Laurel, MD Maryland National ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Johnson and Jenkins Funeral Home 21. Signature of Funeçal Service Licenses 716 Kennedy Street NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on leach line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician SE DILC SHOC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-transit RESDIRATOR Due to (or as a consequence of): P.O. Box 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Dependent 1 ☐ Yes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has autopsy 2 V No 10 perstens 100 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospitei or Attending I within 24 hours after death. To the Funerei Director: After 5 Pending investigation Natural М 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check o and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D5369 ocress of person who completed cause of death (Item 23a) (Type, Print) BETHESOM, MO 6320 DEMOCRAN MD REDDY oln, Day, Ybar, 2005 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 5

|            |  |                     | 1 - State of Maryland / Registrer  | Certificate of Death   | ientai Hygier<br><sub>Reg. I</sub>                  | 2000 42400   |
|------------|--|---------------------|--|--|---|--|
|            | Physici  | an                  | 1. Decedent's Name (First, Middle, Last)   |  |   | Day Year 3. Time of Death  |
|            | /Medic   | al                  | Linda Mae Reckert  4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death   | December  | 7 2005 10:10 p M<br>4c. County of Death                          |
|            | Examin   | er                  | Baltimore Washington Medical Cent  | C 2  | 1   | Anne Arundel   |
|            | Funeral  |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last b  | irthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  | 8. Date of Birth<br>(Month, Day, Yea<br>Feb. 11, 19 |  |
| L          | Director   |                     | 217-40-2726  | Yrs.   | Feb. 11,19  | 943   Maryland   |
|            | yland  |                     |  | wn or Location   |   | 10d. Inside City Limits  |
|            | Ba-fs  | ctor                | MD Prince George's Bow   | rie  |   | 1XIYes 2 No  |
|            | with the   | Dire                | 10e. Street and Number   | 10f. Zip Code  | 10g.  | Citizen of What Country?   |
|            | death<br>ms 23   | neral               | 13303 Yarland Lane 11. Marital Status 12. Was Decedent Ever in U.S.  | 2071 5  13. Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto                    | ecify Yes or No-                                    | USA<br>14. Race - American Indian,                               |
| 21215-0036 | be filed within 72 hours after death with the Maryland tal Hygiene. d other than "neturel", or tlems 23e or 28e-f show event. The Medical Examinat must be multiped at | by Funeral Director | 1 ☐ Never Married 2 【 Married If Yes, Give 13 ☐ Widowed 4 ☐ Divorced Year or Dates:  | If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 🛣 No Specify:   | Rican, etc.)  | Black, White, etc.  Specify: White                               |
| 2-0        | 72 ho  | Completed           | 15. Decedent's Education (Specify only highest grade completed)  | a. Decedent's Usual Occupation<br>(Give kind of work done during most of work<br>life. DO NOT use retired) | ing 16b.  | . Kind of Business/Industry                                      |
| 121        | within<br>ene.<br>than than  | Jup                 | Elementary/Secondary (0-12) College (1-4or 5+)   | Interior Decorating  | i   | ome Decor  |
|            | e filed<br>Il Hygie<br>other   | Be Co               | 17. Father's Name (First, Middle, Last)  |  | First, Middle, Maid                                 |  |
| ylar       |  | To E                | Thomas G. Carrill  |  | Lee Baile   | *  |
| Maryland   |  |                     | 19a. Informant's Name/Relationship (Type, Print) 19  Robert E. Reckert / spouse  | b. Mailing Address <i>(Street and Number or Rura</i><br>13303 Yarland Lane                                 | al Route Number, Cit<br>Bowie, MD                   |  |
|            | s 1 and 3<br>f Health<br>item 27<br>other tr   |                     | 20a. Method of Disposition 20b. Place  |  |   | Location - City or Town, State                                   |
| ш          | nit. Pages<br>bartment of liortant: If it<br>injury or o   |                     | 1 Li Buriai 2 (Moremation 3 Li Hemovai from State  | olitan Crematory 12/1  | 2/2005 A  | lexandria, VA.   |
| Baltimore, | permit. Pages 1 a Department of Hee Important: If item any injury or othe  |                     | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility Be 6512 NW Crain Hwy.   | all Funera<br>Bowie, I                              |  |
|            | £.   |                     | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.         | o not enter the mode of dying, such as cardiac   | or respiratory arrest,                              | Approximate<br>Interval Between                                  |
|            | Physician<br>/Medical  |                     | Immediate Cause (Final disease or condition resulting in death)  | CANCER   |   | Onset and Death  |
| 1          | Examiner   |                     | Due to (or as a construence  | a of):   |   |  |
|            | P #  | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes of the property of that initiated events c. | e of):   |   |  |
|            | ecuter<br>and<br>I-trans   | Examiner            | Cate Clease of fair that initiated events resulting in death) Last   | a of):   |   |  |
| 68760,     | tificate be executed<br>ig physician and<br>as the burial-transit  |                     | d  | - <del></del>  |   |  |
|            | ± 50 €   | Medical             | IF FEMALE:   |  |   |  |
| Вох        | feath certificate b<br>attending physic<br>I for use as the b  | Physiclan/N         | 23b. Was decedent pregnant in the past 12 months?  | th 3 Ectopic pregnancy 5 Other (specify)   |   | 23d. Date of delivery<br>Month Day Year                          |
| 0          | that the de<br>led by the a  | hysic               | 1   Yes 2   No 9   Unknown 9   Unknown   | o a outst (appoint)  |   |  |
| rds, P     | w requires tha<br>been signed I<br>should be det   | by                  | Part II. Other significant conditions contributing to death but not resulting  | in the underlying cause given in Part I.   |   | ouse contribute to the cause of death?                           |
| Records,   | as s   | Completed           |  |  | 24a. Was an autopsy performed                       |  |
| Vital      | Physicien: The<br>this certificate har<br>ral director, page   | Be                  | 25. Was case referred to medical examiner?   |  | (Check only one)                                    |  |
| of         | Physic<br>r this or  | To To               | 27. Manner of Death 28a. Date of Injury 28b.   |  | me 5 Residence<br>28d. Describe how in              | 6 ☐Other (Specify)   |
| ion        | Attending I<br>ir death.<br>ector: After<br>by the funer   | atlor               | 1 XNatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation  | Injury Work?  M 1 ☐ Yes 2 ☐ No   |   |  |
| Division   | el or Atte<br>s after det<br>il Directo<br>ed in by th   | Certification:      | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)   | farm, street, factory, office  | 28f. Location (Street<br>City or Town, St           | and Number or Rural Route Number,<br>ate)                        |
|            | To the Hospitel or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral                                      | Medical (           | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge on the basis of examination a and manner stated.        | ge, death occurred at the time, date and place, ind/or investigation, in my opinion, death occurr          | and due to the cause<br>ed at the time, date a      | o(s) and manner as stated.<br>and place, and due to the cause(s) |
|            | To the within To the comple  | ž                   | 29b. Signature and title of certifier  | 29c. License number  |   | Date signed (Month, Day, Year)                                   |
| <u></u>    | Til  |                     | 1ten tran  | P 0 2 7 4 1 5  | 1/2   | Cember +, 200-   |
| R          | (Y)  | l li                | BATMER WAShing Win Arch  | CTYPE, Print) LAI CENTER, HENRY  | y FRANC   | cember 7,2005<br>CIC M.P.  |
|            | Sta<br>Registi   |                     | 31, Date filed (Month, Day, Year) DEC 1 2 2005   | fort.  | 1   |  |

DHMH 17 Rev 1/2001

Reckert Linda

REED

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|                   |  |                  | 1 - State<br>Registrar  | State of Marylan   | -                            | artment of He                                 |                                     |                                  | iene 005                            | 42401  |
|-------------------|--|------------------|---|--|------------------------------|---|-------------------------------------|----------------------------------|-------------------------------------|--|
|                   |  |                  | 1. Decedent's Name (First, Middle, Las                                  | t)   |                              |   |                                     | 2. Date of Dea                   | th                                  | 3. Time of Death                                   |
| н                 | Physici:<br>Medic/   |                  | GREGORY C. REED   |  |                              |   |                                     | DECEMBEI                         | $\frac{10}{10}$ , $2005$            | 6:45A. M   |
| -                 | Examin   |                  | 4a. Facility Name (If not institution, give                             | street and number)   |                              | 4b. City, Town, or Lo                         | ocation of Death                    |                                  | 4c. County of Deat                  |  |
|                   |  |                  | SOUTHERN MARYLAND   |  |                              | CLINTON                                       |                                     |                                  | PRINCE GE                           | CORGES   |
|                   | Funeral  |                  | 5. Social Security Number 6. Se   | ŪM 2□F   | Ven                          |   | f Under 24 Hrs.<br>Hours Min.       | 8. Date of Birth<br>(Month, Day  | Year) Co                            | hplace (State or Foreign<br>untry)                 |
|                   | Director   |                  | 214 08 5664 Usual Residence of Decedent                                 |  | 30 115.                      |   |                                     | OCT. 06                          | , 1975 WAS                          | HINGTON, DC  |
|                   | yland  |                  | 10a. State 10b. County  | 10c. City  | , Town or Lo                 | cation  |                                     |                                  |                                     | 10d. Inside City Limits                            |
|                   | Mar<br>Pa-f st   | ţċ               | MARYLAND PRINCE GI  | EORGES CLT   | NTON                         |   |                                     |                                  |                                     | M∑Yes 2 □ No                                       |
|                   | or 28  | Funeral Director | 10e. Street and Number  |  |                              | 10f. Zip Code                                 |                                     | 1                                | 0g. Citizen of What Co              | untry?   |
|                   | 23a  | le l             | 10401 LIBATION COL  | JRT  |                              | 2   | 0735                                |                                  | UNITED ST                           | ATES   |
|                   | teme   | nue              | 11. Marital Status  | 12. Was Decedent Ever in U.<br>Armed Forces?                     |                              | Was Decedent of Hisp<br>f Yes, specify Cuban, | anic Origin? (Sp<br>Mexican, Puerto | ecify Yes or No-<br>Rican, etc.) | 14. Race - Ame<br>Black, White      |  |
| 36                | s afte   | by F             | XX Never Married 2 Married 3 Widowed 4 Divorced                         | 1 ☐ Yes XXX No<br>If Yes, Give<br>Year or Dates:                 |                              | ☐ Yes XX No                                   | Specify:                            |                                  | Specify: BL                         | ACK  |
| 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>than 'natural', or iteme 23a or 28a-f show<br>ta Medical Examirar must be notified at   | edi              | 15. Decedent's Ed   |  | 16a, Deced                   | lent's Usual Occupation                       | on                                  |                                  | 16b. Kind of Business/              |  |
| 212               | 7 nin 7  | plet             | (Specify only highest grades) Elementary/Secondary (0-12)               | de completed)  College (1-4or 5+)                                | (Give                        | kind of work done dur<br>DO NOT use retired)  | ring most of work                   | ing                              |                                     |  |
| 21,               | d with   | Completed        | 12TH  | College (1-401 3+)   | ELE                          | CTRICIAN                                      |                                     |                                  | PRIVATE                             |  |
| p                 | 2 should be filed within 72 hours after death with the Marylar<br>n and Mental Hygiene.<br>I is marked other than "natural", or iteme 23a or 28a-f show<br>raumatic avent, it's Medical Exemplear must be notilled at  | Be (             | 17. Father's Name (First, Middle, Last)                                 |  |                              | 1:  | 8. Mother's Nam                     | e (First, Middle, i              | Maiden Sumame)                      |  |
| yla               | should trind Ment  | ဥ                | CLIFFORD M. REED  |  |                              |   | PRISCIL                             | LA E. HA                         | RVEY                                |  |
| Maryland          | s 1 and 2 should<br>if Health and Men<br>item 27 is marke<br>other traumatic   |                  | 19a. Informant's Name/Relationship (7                                   |  |                              |   |                                     | al Route Number                  | City or Town, State, 2              | (ip Code)  |
|                   | s 1 and 2<br>of Health<br>Item 27 other tra  |                  | PRISCILLA E. REEI  20a. Method of Disposition                           | ,  |                              | LIBATION<br>sition (Name of                   |                                     |                                  | MD 20735<br>20c. Location - City or | Town Ciata   |
| Baltimore,        | nt of the state of |                  | XXBurial 2 ☐ Cremation 3 ☐  | Removal from State   | emetery, cren                | natory or other place)                        | 1                                   |                                  | zoc. Eccation - City or             | Town, State  |
| 틒                 | artme<br>ortent  |                  | 4 □Donation 5 □ Other (Specify  21. Signeture of Funeral Service Licen  |  |                              | ION CEMETE  Name and Address                  |                                     | 5/2005                           | CLINTON, 1                          | MD   |
| Ba                | permit. Pages 'Department of H<br>Importent: If Ite<br>any Injury or of  |                  | PM  | 000  |                              | MARSHALL'S                                    | FUNERA                              |                                  | F MARYLAND                          |  |
|                   |  |                  | 23a. Part 1 Enter the disease, or comp                                  | olications that caused the death                                 |                              |   |                                     |                                  | LAND, MD 20                         | Approximate  |
|                   | Physician  | ,                | shoot or heart failure. List only of immediate Cause (Final             | Multipl  | 0 16                         | iariel  |                                     |                                  |                                     | Interval Between<br>Onset and Death                |
|                   | /Medical   |                  | disease or condition resulting in death)                                | a. Due to (or as a consequ                                       |                              | 100.007                                       |                                     |                                  |                                     |  |
|                   | Examiner   |                  | Sequentially list conditions,   | b  |                              |   |                                     |                                  |                                     |  |
|                   | D #  | Examiner         | if any, leading to immediate cause. Enter Underlying                    | Due to (or as a consequ  | uence of):                   |   |                                     |                                  |                                     |  |
|                   | and I-trans  | хаш              | Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a consequ   | ionoo of):                   |   |                                     |                                  |                                     |  |
| 8760,             | ate be executed<br>hysicien and<br>the burial-transit  | alE              |   | Due to (or as a consequ  | 2611C8 OI).                  |   |                                     |                                  |                                     |  |
| 687               | , u  | edical           | <u> </u>  | d  |                              |   |                                     |                                  |                                     |  |
| Box               | attending<br>for use as  | N/M              | IF FEMALE:<br>23b. Was decedent pregnant                                | 23c. If yes, outcome of pregna                                   |                              |   |                                     |                                  | 23d. Date of del                    | verv   |
|                   | death<br>e atten   | by Physician/Me  | in the past 12 months?  | 1 Live birth 2 Fetal 4 Pregnant at time of de                    |                              | Ectopic pregnancy<br>Other (specify)          |                                     |                                  | Month                               | Day Year   |
| P.0               | the<br>by th   | hys              | 9 Unknown   | 9□ Unknown   |                              |   |                                     |                                  |                                     |  |
|                   | w requires that the been signed by the should be detached  | by F             | Part II. Dther significant conditions or                                | ontributing to death but not resu                                | ulting in the ur             | nderlying cause given                         | in Part I.                          |                                  | pacco use contribute to             |  |
| ord               | requir   | Completed        |   |  |                              |   |                                     | 1 U Y                            | es 2                                | obably 4 Unknown                                   |
| Sec.              | s t  | nple             |   |  |                              |   |                                     | 24a. Was a autops                | y prior to d                        | topsy findings available<br>completion of cause of |
| ᆵ                 | the ete  |                  |   |  |                              |   |                                     | 1 X Yes                          | ned? death?<br>2 ☐ No 1 ☐ Yes       | 2 No   |
| of Vital Records, |  | Be c             | 25. Was case referred to medical examiner?                              | Hospital:  |                              | Other   |                                     | h (Check only on                 |                                     |  |
| ō                 | Physic ruthis aral di  | To to            | 1 ☐Xes 2 ☐ No  27. Manner of Death                                      | 1 ☐ Inpatient 2 💢 28a. Date of Injury (Month, Day Year)          | ER/Outpatien<br>28b. Time of | 1 3L DOA                                      |                                     |                                  | ence 6 Other (Spec                  | cify)  |
| Ö                 | Attending<br>ir death.<br>ector: After<br>by the fune  | atlor            | 1 □Natural 5 □ Pending 2 NAccident investigation                        |  | Injury                       | 28c. Injury a<br>Work?<br>1 ☐ Ye              | s 2 No                              | Driver of                        | motor vehil                         | de that  |
| Division          | i or Attend<br>efter death<br>Director: /  | Certification;   | 3 Suicide 6 Could not be<br>4 Homicide determined                       |  | me, farm, str                | -   |                                     | 28f. Location (Si                | root and Number of Pr               | ral Route Number,                                  |
| Ö                 | rs efter self self self self self self self self   | Cer              |   | building, stc. (Spacin)  | Road                         |   |                                     | Rd FT V                          | 1 1                                 | nd of Trucker                                      |
|                   | To the Hospital or Attending Ph<br>within 24 hours effer death.<br>To the Funeral Director: Affer th<br>completely filled in by the funeral  | cal              | 29a. Certifier 1 Certifying Ph  | ysician: To the best of my kno<br>liner: On the basis of examina | wledge, death                | occurred at the time,                         | date and place,                     | and due to the c                 | ause(s) and manner as               | stated.  |
|                   | To the within 2 To the Complet   | Medical          | one)  | and manner stated.   |                              |   |                                     |                                  |                                     |  |
|                   | 5 <u>18 6</u> 9  |                  | 29b. Signature and title of certifier                                   | mo   |                              | 29c. License n                                |                                     |                                  | 9d. Date signed (Monti              |  |
| Λ                 | (  |                  | 20 Name and address of severe   | *  | 00-) 7                       | O.C.M.  | E.                                  | D                                | ECEMBER 11                          | , 2005   |
| *                 | (5)  |                  | 30. Name and address of person who d                                    | ~  | ı∠3a) (1ype,                 |   | STREET 1                            | BALTIMOR                         | E MARYLAND                          | 21201  |
|                   | Sta  | te               | 31. Date filed (Month, Day, Year)                                       | ■ Registrar's Signa  | ture                         |   |                                     |                                  |                                     | _  |
|                   | Regist   |                  | DEC 1 3 200   | plean &  | fre                          | B)  |                                     |                                  |                                     |  |

DHMH 17 Rev 1/2001

Registrar

DEC 1 4 2005

ORIGINAL

# Amended Item 11 per F.D. 12/12/2005 Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |   |                | 1 - For<br>State<br>Registrar  | State of Man  |                       | artment of F          |                     |                                 | giene<br>Reg. No.            | 005                    | 424                 | 03       |
|------------|---|----------------|--|---|-----------------------|-----------------------|---------------------|---------------------------------|------------------------------|------------------------|---------------------|----------|
|            |   |                | 1. Decedent's Name (First, Middle, La                                      | st)   |                       |                       | -                   | 2. Date of De                   | ath                          |                        | 3. Time of E        | Death    |
|            | Physici   |                | Francis  | Suter   |                       |                       |                     | Month /2                        | O5                           | 2005                   | 3:05                | - An     |
|            | /Medio<br>Examin  |                | 4a. Facility Name (If not institution, giv                                 | e street and number)                                |                       | 4b. City, Town, o     | r Location of Death |                                 |                              | ounty of Death         |                     |          |
|            | Lxaiiii   |                | Greater Baltimor   | e Modical C   | antor                 | The same              | _                   |                                 |                              | D-11-4                 |                     |          |
|            | Funeral   |                | 5. Social Security Number 6. S   |   | r yrs. last birthday) | TOWSO                 | If Under 24 Hrs.    | 8. Date of Bir                  | th                           | Baltir<br>9. Birthp    | place (State or     | Foreign  |
|            | Director  |                | 212-36-0351  | 2 M 2 □ F   | 67 Yrs.               | Months Days           | Hours Min.          | (Month, Da                      | 1 <i>y</i> , Year)<br>23 /93 | Coun                   | ntry)               |          |
|            |   |                | Usual Residence of Decedent  |   |                       |                       |                     | 1 67                            | 71-                          |                        | aryland             | 1        |
|            | ylan  |                | 10a. State 10b. County   |   | c. City, Town or Lo   | ocation               |                     |                                 |                              | 1                      | Od. Inside City     |          |
|            | Ma-1-s  | to             | MD Balt  | timore  | Pike                  | sville                |                     |                                 |                              |                        | 1 Tyes              | 2 □ No   |
|            | 7 28  | Director       | 10e. Street and Number   |   |                       | 10f. Zip Code         |                     |                                 | 10g. Citize                  | n of What Cour         | ntry?               |          |
|            | h wit   |                | 600 McHenry Roa  | ad  |                       |                       | 21208               |                                 | Unite                        | ed State               | 25                  |          |
|            | d within 72 hours after death with the Maryland<br>Jone.<br>Ir than "natural", or items 23a or 28a-1 show<br>Ir be Madical Examiner must be motified at | Funeral        | 11. Marital Status   | 12. Was Decedent Eve<br>Armed Forces?               | r in U.S. 13.         | Was Decedent of H     | ispanic Origin? (Sp | pecify Yes or No                |                              | Race - Americ          | can Indian,         |          |
| 9          | or ite  |                | 1 Never Married  | 1 ☐ Yes 2 No  |                       |                       |                     | o Alcan, etc.)                  |                              | Black, White,          |                     |          |
| 8          | all, c  | þ              | <b>3</b> Widowed 4 □ Divorced  | If Yes, Give<br>Year or Dates:                      |                       | 1 ☐ Yes 2 🕱 No        | Specify:            |                                 | S                            | pecify: Whi            | .te                 |          |
| 21215-0036 | 72 hc   | Completed      | 15. Decedent's Education (Specify only highest graduation)                 |   | 16a. Dece             | dent's Usual Occup    | ation               | kina                            | 16b. Kind                    | of Business/Ind        | dustry              |          |
| 2          | within ene.   | ple            | Elementary/Secondary (0-12)  | College (1-4or 5+)                                  | life.                 | DO NOT use retired    | d)                  | NII 9                           |                              |                        |                     |          |
| 2          | o d will  | NO.            | 12th   |   |                       | Automot               | ive Techr           | nician                          | Owne                         | r Suter                | Perfo               | rmanc    |
|            | be filed within tal Hygiene. d other than 'event, the Me  | Be (           | 17. Father's Name (First, Middle, Last,                                    | )   |                       |                       | 18. Mother's Nam    | ie (First, Middle               | . Maiden Su                  | ımame)                 |                     |          |
| <u>a</u>   | 0 0 0   | ToE            | Arthur Gable   | Suter   |                       |                       | Mari                | le Agnes                        | Park                         |                        |                     |          |
| Maryland   | s 1 and 2 should be 1<br>f Health and Mental I<br>item 27 Is marked of<br>other traumatic eve   | _              | 19a. Informant's Name/Relationship (                                       | Type, Print)  | 19b. Mailie           | ng Address (Street    |                     |                                 |                              |                        | Code)               |          |
|            | 5 = 7 :   |                | Phillip Suter  | son   | 47                    | 701 Ridge             | Road Mt             | . Airv.                         | MD                           | 21771                  |                     |          |
| altimore,  | s 1 and 2<br>if Health<br>item 27   |                | 20a. Method of Disposition   |   | 20b. Place of Dispo   | sition (Name of       |                     | Date                            |                              | tion - City or To      | wn, State           |          |
| 10         | permit. Pages Department of I Important: If ite any injury or of  |                | 1 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Bonation 5 ☐ Other (Specif                 |   |                       | natory or other place | ·                   | 12 20                           | OF D                         |                        | 1 100               |          |
| ⋣          | artme<br>artme<br>ortan<br>injur  |                | 21. Signature of Fineral Service Licer                                     |   |                       | les Ceme              |                     | 12, 20                          | 05 P                         | 1KesV11                | Te, MD              |          |
| Ba         | Depa<br>Impo<br>any i   |                | Ima B  | len.  | l I                   | Burrier-O             | ueen Fune           | ral Hom                         | e & C                        | remator                | v. PA               |          |
|            |   |                | 23 Pa 1. Enter the disease, or com   | plications that caused the                          | doath Do not on       | 212 W. O              | ld Libert           | y Road                          | Winfi                        | eld, MD                | 2179<br>Approxima e | 4        |
|            |   |                | shock, or heart failure. List only   | one cause on each line.                             |                       | 1                     | ly, such as cardiac | or respiratory a                | rrest,                       |                        | Interval Betwo      | /een     |
|            | Physician   |                | mme late Cause (Final disease or condition                                 | a fulmono   | ira emb               | olus                  |                     |                                 |                              | /                      | Minut               | 25       |
|            | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as a co                                  | onsequence of):       |                       |                     |                                 |                              |                        | 4111                |          |
|            | LAAIIIIIEI  |                | Sequentially list conditions,  | b   |                       |                       |                     |                                 |                              |                        |                     |          |
|            | p =   | Examiner       | if any, leading to immediate Cause (Disease or injury                      | Due to (or as a co                                  | onsequence of):       |                       |                     |                                 |                              |                        |                     |          |
|            | ocute<br>nd<br>trans  | аш             | that initiated events  | c   |                       |                       |                     |                                 |                              |                        |                     |          |
| oʻ         | e exe<br>ian a<br>irial-  | Ä              | resulting in death) Last   | Due to (or as a co                                  | onsequence of):       |                       |                     |                                 |                              |                        |                     |          |
| 8760,      | icate be executed<br>physician and<br>s the buriat-transit  | dical          |  | _ d   |                       |                       |                     |                                 |                              |                        |                     |          |
| 9          | ntifica<br>ng ph<br>as t  | Aed            | IE EENALE.   |   |                       |                       |                     |                                 |                              |                        |                     |          |
| Вох        | death certifica<br>attending pla<br>d for use as t  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant                                   | 23c. If yes, outcome of p                           |                       | Ectopic pregnancy     | ,                   |                                 | 230                          | d. Date of delive      | •                   |          |
|            | deat<br>e att   | ICI            | in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \) | 4☐Pregnant at time                                  |                       | Other (specify)       |                     |                                 |                              | Month                  | Day Ye              | ear      |
| 0          | that the de<br>ed by the<br>detached  | hys            | 9 🗆 Unknown  | 9□ Unknown  |                       |                       |                     |                                 |                              |                        |                     |          |
| ٦,         | law requires that the death certificate been signed by the attending 1.2 should be detached for use as  | by P           | Part II. Other significant conditions of                                   | contributing to death but n                         | ot resulting in the u | nderlying cause giv   | en in Part I.       | 23e. Did t                      | obacco use                   | contribute to th       | e cause of de       | ath?     |
| Records,   | quire<br>n sig<br>ald bu  | D D            | Atheroselerotic o  | coronary ar   | tery dis              | ease                  |                     | 10                              | Yes 2 1                      | No 3□ Prob             | ably 4 Ur           | nknown   |
| 00         | w requir<br>been si<br>should   | Completed      | Chance lawler  | leg ulcer   |                       |                       |                     | 24a. Was                        | an S                         | 24b. Were autor        | nsv findings a      | vailable |
| Re         | <b>a</b> – <b>a</b>   | E G            | CALL DILLE LOW CA  | 109 4109  |                       |                       |                     | autor                           | osy<br>ormed?                |                        | mpletion of cau     |          |
| 8          | n: T)<br>licate<br>r, pa  |                |  |   |                       |                       |                     | 1 Yes                           | 2 No                         | 1 Z Yes                | 2 No                |          |
| Vital      | Physician: Th<br>this certificate<br>ral director, pag  | Be             | 25. Was case referred to medical examiner?                                 | Hospital:   |                       | oth Oth               | 26. Place of Dear   |                                 |                              |                        |                     |          |
| o          | d is  | 7              | 1 Yes 2 No   | 1 Minpatient  | 2 ER/Outpatier        | I 3L DOA              | 4   Nursing H       | ome 5 Resi                      |                              |                        | 1)                  |          |
| Ē          | ding f  | ono            | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending                                | 28a. Date of Injury<br>(Month, Day Ye               | 28b. Time o<br>lnjury | Wor                   | k?                  | 28d. Describe I                 | now injury o                 | ccurred                |                     |          |
| Division   | Attending r death. ector: After by the fune   | Certification: | 2 Accident investigation 3 Suicide 6 Could not b                           |   |                       |                       | Yes 2 □ No          |                                 |                              |                        |                     |          |
| $\leq$     | l or Attendatter deatl<br>Director:   | ij             | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined                     |   |                       | eet, factory, office  |                     | 28f. Location (3<br>City or Tox |                              | Vu <i>mber</i> or Rura | I Route Numbi       | er,      |
|            | Hospital or<br>14 hours afte<br>Funeral Dir<br>tely filled in   |                |  | 10  |                       |                       |                     |                                 |                              |                        |                     |          |
|            | fosp<br>hou<br>une<br>aly fil   | edical         | 29a. Certifier Certifying Ph<br>(Check only 2 Medical Exar                 | sysician: To the best of miner: On the basis of exa | y knowledge, deatl    | n occurred at the tin | ne, date and place, | and due to the                  | cause(s) an                  | id manner as st        | ated.               |          |
|            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral             |                | one)   | and manner stated                                   |                       |                       |                     |                                 |                              |                        |                     |          |
|            | To 1  | Σ              | 29b. Signature and title of certifier                                      | 0 11  |                       | 29c. License          | e number            |                                 |                              | signed (Month, I       |                     |          |
| •          | WIL   |                | Harlin Ma  | mell. M.  | <b>A</b>              | DY                    | 1221                | /                               | )erem                        | ber, 8,                | 2009                | 5        |
|            | MJ  |                | 30. Name and address of person who   | completed cause of death                            | (Item 23a) (Type,     | Print)                |                     | 11.                             |                              | -                      |                     |          |
|            | 13  |                | Philip McDowel   | LM.D. G.BI  | n.c. 670              | 1 North C             | harles St           | Balti                           | more,                        | m1) 2                  | 1204                |          |
|            | Sta   | ite            | 31. Date filed (Month, Day, Year)  | 32. Registrar's                                     | Signature             | 4                     |                     | ,                               |                              |                        | -                   |          |
|            | Regist  | rar            | DEC 12   | 2005  | a &                   | Cocile                |                     |                                 |                              |                        |                     |          |

|  |   |                  |   | tate of Maryland  | / Depa                            |  | lealth and N                                | nental Hyg                                  | _  | 42404   |
|--|---|------------------|---|---|-----------------------------------|--|---|---|--|---|
|  |   |                  | Decedent's Name (First, Middle, Last)   |   |                                   |  |   | 2. Date of Dear<br>Month                    |  | 3. Time of Death                              |
|  | hysicia<br>/Medic   |                  | Oscar Lesl  | ie Shafer   |                                   |  |   | Dec.  | 10, 2005                                       | 1 PM M  |
|  | xamin   |                  | 4a. Facility Name (If not institution, give stree   |   | _ 1                               |  | r Location of Death                         |   | 4c. County of Death                            |   |
|  |   |                  | Frederick Memo  |   |                                   |  | derick                                      | 10  | Freder   |   |
|  | neral<br>ector  |                  | 5. Social Security Number 213-03-0151  Usual Residence of Decedent  | 7. Age (In yrs. last  | Yrs.                              | If Under 1 Year<br>Months Days                 | Hours Min.                                  | 8. Date of Birth<br>(Month, Day)<br>Mar • 2 | Year) 9. Birth Coul.<br>1, 1919 M              | place (State or Foreign<br>ntry)<br>D         |
| land   | Mo to   |                  | 10a. State 10b. County  | 10c. City, T  |                                   |  |   | · · · · · · · · · · · · · · · · · · ·       |  | 10d. Inside City Limits                       |
| Mary   |   | ţċ               | MD Freder   | ick   | M                                 | iddleto  | wn  |   |  | 1 <b>x</b> Xies 2 ☐ No                        |
| be filed within 72 hours after death with the Maryland tall Hygiene.     | 3a or 28a   | Funeral Director | 10e. Street and Number 2 Locust B   | lvd.  |                                   | 10f. Zip Code                                  | 1769  | 1   | 0g. Citizen of What Cou<br>USA                 | ntry?   |
| death  | E mar   | ner              | 11. Marital Status  | Was Decedent Ever in U.S.<br>Armed Forces? 1 Q / /  | 13. \                             | Was Decedent of H                              | dispanic Origin? (Sp<br>an, Mexican, Puerto | pecify Yes or No-                           | 14. Race - Ameri<br>Black, White               |   |
| hours after  | Evaluation  | þ                | 1 Never Married 2 Married   | Armed Forces?<br>□ Mores 2 □ No 1944<br>f Yes, Give<br>Year or Dates: 1946                            |                                   | Yes 2 XNo                                      | Specify:                                    | riour, oto.,                                | Specify:Whi                                    |   |
| nin 72 ho  | n "natur<br>Medical   | Completed        | 15. Decedent's Educatic<br>(Specify only highest grade co   |   | (Give<br>lite. l                  |  | pation<br>during most of world)             | king  | 16b. Kind of Business/Ir                       | ldustry                                       |
| d with   | ar the  | E O              | II  | 50/legb (1-40/ 54)  | sal                               | Lesman   |   |   | furnitur                                       | е   |
| d be file  | vent  | Be               | 17. Father's Name (First, Middle, Last)   | <b>.</b> .  |                                   |  |   |   | Maiden Surname)                                |   |
| 2 should be and Mental   | arke<br>atic e  | 2                | Oscar L. Sha  |   |                                   |  |   | ayetta                                      |  |   |
| ind 2 shotalth and   | 27 Is m<br>ar traum   |                  | Nancy Allen (Da   |   |                                   |  |   |   | dletown, State, Zi, $d$ 1etown,                |   |
| nore,  | it: If Item<br>y or othe  |                  | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Remo 1 □ Denation 5 □ Other (Specify)   | oval from State 20b. Place ceme   | e of Dispo<br>etery, cren<br>hera | sition (Name of natory or other place) an ceme | tery 12                                     | 110   | 20c. Location - City or T Middletow            |   |
| Department of Health and Mental  | mportar<br>any injur<br>once.   |                  | 21. Storaure of Funeral Service Licensee  | 0018  | 22                                | Name and Addre                                 | B of Facility om p                          | son Fu                                      | neral Hom                                      | e   |
|  |   | 1                | Pag*. Enter the Sease, or complication shock, or heart failure. List only one care  | ons that caused the death. [  |                                   |  |   |   | etown, MD                                      | Approximate                                   |
| /Me  | ician<br>dical<br>niner   |                  | Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a consequen   | le                                | myo  | eartie                                      | 11 1  | fasetion                                       | Interval Between<br>Onset and Death           |
| ite be executed  | ysician and<br>he burial-transit  | icai Examiner    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d | Due to (or as a consequen   |                                   |  |   |   |  |   |
| the death certificate  | ed by the attending physician and<br>detached for use as the burial-transit | hysiclan/Med     | in the past 12 months?  | f yes, outcome of pregnancy<br>1□Live birth 2□ Fetal de<br>4□ Pregnant at time of death<br>9□ Unknown | ath 3                             | Ectopic pregnancy                              | у   |   | 23d. Date of deliv<br>Month                    | rery<br>Day Year                              |
|  | s been signed b   | by P             | Part II. Other significant conditions contrib   | uting to death but not resultin   | ng in the u                       | nderlying cause gru                            | ven in Part I.                              | 23e. Did to                                 | bacco use contribute to t                      | the cause of death?                           |
| e law  | has<br>je 2   | Completed        |   |   |                                   |  |   | 24a. Was a autops perform                   | med? prior to co                               | opsy findings available ompletion of cause of |
| _  | certificate<br>rector, pag  | O e              | 25. Was case referred to medical  |   |                                   |  | 26 Place of Dea                             | 1 ☐ Yes                                     |  | 2 □ No  |
| OT VITA Physician:   | s cert<br>direct  | 0                | examiner?<br>1 ☐ Yes 2 No Hosp  | ital: 1 Inpatient 2 ☐ ER  | /Outpatien                        | t 3□ DOA Ott                                   | 200   |   | ence 6 □Other (Speci                           | fv)   |
| on or<br>ding Phy  | tor: After this certific<br>the funeral director,                           | tion; T          |   |   | b. Time of<br>Injury              | 28c. Injui<br>Wor                              | ry at                                       |   | ow injury occurred                             | <i>y</i>                                      |
| DIVISION O  To the Hospital or Attending Pi within 24 hours after death. | I Director:<br>d in by the  | Certification:   | a Carlo a contract has a  | 8e. Place of Injury - At home building, etc. (Specify)  | , farm, str                       | eet, factory, office                           |   | 28f. Location (St<br>City or Town           | treet and Number or Run<br>n, State)           | al Route Number,                              |
| e Hospita<br>24 hours  | e Funera<br>etely fille   | edical C         | 29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Examiner:   | in: To the best of my knowle<br>On the basis of examination<br>and manner stated.                     | dge, death<br>and/or in           | estigation, in my o                            | opinion, death occur                        | rred at the time, d                         | ate and place, and due t                       | o the cause(s)                                |
| Nithin   | To th   | Me               | 29b. Signature and title of certifier   |   |                                   | 29c. Licens                                    | se number                                   | 2   | 9d. Date signed (Month,                        | Day, Year)                                    |
|  |   |                  | ) X-Cd  | m M:  | $\Omega$                          | Di   | 58391                                       |   | 12-14-   | 05  |
| DXIV   | A   |                  | 30. Name and address of person who complete A TTAD A 2  | eted cause of death (Item 23  | (Type,                            | Print) Print)                                  | toruse t                                    | Ine F                                       | 9d. Date signed (Month,<br>12-14-<br>redeniels | MO  |
|  | Sta   |                  | 31. Date filed (Month, Day, Year)   | 32. Registrar's Signature   | 3                                 |  |   |   | 2  | 21701   |
|  | Registr   | 121              |   |   |                                   |  |   |   |  |   |

|                     |   |  | Registrar  | aryland / Dep<br><i>Ce</i>   | artment of F<br>ertificate of  | Health and M<br>Death  |  | giene 05   | 42405   |
|---------------------|---|--|--|--|--|--|--|--|---|
|                     | Physici   | an                                     | 1. Decedent's Name (First, Middle, Last) Steve Jerome Simonson   |  |  |  | 2. Date of Dea<br>Month  | ath<br>Day Yeer  | 3. Time of Death  |
| П                   | /Medic  | al                                     |  |  |  |  | Decembe  |  |   |
|                     | Examin  | er                                     | 4a. Facility Name (If not institution, give street and number)  8 Squirrel Court   |  | Elkton   | or Location of Death   |  | 4c. County of Dea  | ath   |
|                     | Funeral   |  | 5. Social Security Number 6. Sex 7. Age  | (In yrs. last birthday)  | If Under 1 Year  | If Under 24 Hrs.   | 8. Date of Birtl   | Cecil  | rthplace (State or Foreign  |
|                     | Director  |  | 473-52-7113 <sup>1፟፟፟፟፟™ 2□F</sup>   | 59 Yrs.  | Months Days  | Hours Min.   | (Month, Da) Jan 17   | v, Year) C   | ountry)<br>nesota   |
|                     | and<br>w  |  | Usuel Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Le  | ocation  |  |  |  |   |
|                     | f sho   | ō                                      | Maryland Cecil   | Elkton   |  |  |  |  | 10d. Inside City Limits 1 ☐ Yes ②CNo  |
|                     | ath with the Marylan<br>23a or 28a-f show   | Funeral Directo                        | 10e. Street and Number   |  | 10f. Zip Code  |  |  | 10g. Citizen of What C   |   |
|                     | h with  | a D                                    | 8 Squirrel Court   |  | 21921  |  |  | nited Stat   | •   |
|                     | ams   | iner                                   | 11. Marital Status 12. Was Decedent E Armed Forces?  | ver in U.S. 13.  |  | dispanic Origin? (Spe<br>an, Mexican, Puerto   |  |  | erican Indian,  |
| 36                  | or it   | by Fu                                  | 1 ☐ Never Married 2 Married 1 M Yes 2 ☐ No   | 10/17/6B   | 1 ☐ Yes 2 ☑ No   |  | 110411, 010.7  |  | White   |
| 3                   | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Itams 23a or 28a-f show<br>ont, Ita Madical Examinat natural be notilined at | ed p                                   | 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  |  | edent's Usual Occup  | astion   |  | 16b. Kind of Business  |   |
| 215                 | nin 72<br>in "na<br>Medis   | Completed                              | (Specify only highest grade completed)   | (Give  | s kind of work done<br>DO NOT use retire   | during most of workii<br>d)  | 1  |  | vindustry   |
| 7                   | filed within I Hygiene. other than  | Com                                    | Elementary/Secondary (0-12) College (1-4or 5-4)  | ' Assis  | stant Chi<br>Acquisiti   | ef of Mato   | erials   | Medical  |   |
| Maryland 21215-0036 | be file<br>tal Hy<br>d oth  | Be                                     | 17. Father's Name (First, Middle, Last) Marcellus Simonson   |  | 1  | 18. Mother's Name  | (First, Middle,  | Maiden Sumame)   |   |
| S                   | Men<br>Marka<br>Marka   | T <sub>o</sub>                         |  |  |  | Nina Pa  |  |  |   |
| <u>a</u>            | permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: if Itam 27 is marked oth any injury or other traumatic event one.                    |  | 19a. Informant's Name/Relationship (Type, Print)   |  |  |  |  | r, City or Town, State,  | Zip Code)   |
| <u>စ</u> ်          | 1 an<br>Heal<br>tam 2   |  | Julie Simonson/Spouse  20a. Method of Disposition  | 20b. Place of Disponentery, cre  |  |  | -  | 1and 21921<br>20c. Location - City or  | Town State  |
| ē                   | Pages<br>ent of<br>nt: if i   |  | 1 Burial 2 Cremation 3 Removal from State  | Mayerdale  | matory or other place<br>e Cremato   | rv   | berl5,   | Newark, De   |   |
| altimore,           | mit. F<br>partm<br>portar<br>/ injur  |  | 21. Signature of ungray Service Licensee   |  | 2. Name and Addre  | 200:   |  | neral Home   |   |
| ñ                   | P S E E G   |  | John Cher  | 12   | 27 South   |  |  |  | yland 21901   |
|                     |   |  | 23a. Pert1. Enter the disease, or complications that caused t<br>shock, or heart failure. List only one cause on each line   |  |  |  |  |  | Approximate<br>Interval Between   |
|                     | Physician   |  | Immediate Cause (Final disease or condition  | TATIC L  | UNG CA   | NCEK   |  |  | Onset and Death  Mon THS  |
|                     | /Medical<br>Examiner  |  |  | consequence of):   |  |  |  |  | 7.57.1717   |
| l I                 |   | er                                     | Sequentially list conditions, if any, leading to immediate b. Due to (or as a  | a consequence of):   |  |  |  |  |   |
| 1                   | uted<br>d<br>ansit  | Examln                                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |  |  |  |  |  |   |
| )<br>J              | be executed<br>ician and<br>burial-transit  | Exa                                    | consisting in double Local   | consequence of);   |  |  |  |  |   |
| 8/6U                | eath certificate be executed<br>attending physician and<br>for use as the burial-transit  | cal                                    | d  |  |  |  |  |  |   |
| ٥                   | certificate<br>Iding phys   | Med                                    | IF FEMALE:   |  |  |  |  |  |   |
| χο<br>Ω             | death of attended for us  | clan                                   | 23b. Was decedent pregnant in the past 12 months?  | 2 Fetal death 3  | ☐Ectopic pregnancy<br>☐ Other (specify)  | 1  |  | 23d. Date of de<br>Month   | livery<br>Day Year  |
| j.                  | y the   | Physician/M                            | 1 Yes 2 No 9 Unknown 9 Unknown   | illie oi dea(ii 5)   | _ Other ( <i>specify</i> )   |  |  |  |   |
| <br>T               | res that the de<br>signed by the a<br>be detached f   | by Pr                                  | Part II. Dther significant conditions contributing to death but  | t not resulting in the u   |  |  | 23e Did tol  | bacco use contribute to  | the cause of death?   |
| 8                   | 0 0 0   | - LO                                   |  | t that rooming in the d  | inderlying cause giv   | en in Part I.  | E 00. D 10 101   |  | the sause of douter.  |
| _                   | en si   |  |  |  | inderlying cause giv   | en in Part I.  | 1 7  | 9S 2 No 3 P  | obably 4 Unknown  |
| ecor                | requi   |  |  |  | inderlying cause giv   | en in Part I.  | 1 <b>3</b> Ye  | n 24b. Were au   | obably 4 Unknown  |
| I Hecor             | The law requiate has been apage 2 should  |  |  |  | inderlying cause giv   | en in Part I.  | 24a. Was a autops perform  | an 24b. Were at  | obably 4 Unknown  |
| итан месог          | The law requiate has been spage 2 should  | Be Completed                           | 25. Was case referred to medical examiner?   |  |  | 26. Place of Death   | 24a. Was a autops perforr  | 24b. Were at prior to death?   | obably 4 Unknown  |
| or vital Records,   | The law requiate has been spage 2 should  | To Be Completed                        | examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatien  | nt 2□ER/Outpatier  | nt 3 DOA Oth   | 26. Place of Death<br>er: 4 \( \) Nursing Hom  | 24a. Was a autops perform 1 Yes (Check only only only only of the state of the stat | 24b. Were at prior to death? 2 PNo 1 Yes   | obably 4 Unknown utopsy findings available completion of cause of 2 No                                    |
| ō                   | Physician: The law requi<br>this certificate has been s<br>ral director, page 2 should  | To Be Completed                        | examiner?  1 Yes 2 No Hospital: 1 Inpatien  27. Manner of Death 1 Natural 5 Pending (Month, Day)   | nt 2□ ER/Outpatier   | nt 3 DOA Oth   | 26. Place of Death<br>er: 4 ☐ Nursing Hom<br>y at 2  | 24a. Was a autops perform 1 Yes (Check only only only only of the state of the stat | 24b. Were at prior to death? 2 No 1 Yes  | obably 4 Unknown utopsy findings available completion of cause of 2 No                                    |
| ō                   | Physician: The law requi<br>this certificate has been s<br>ral director, page 2 should  | To Be Completed                        | examiner?  1  Yes 2 No Hospital: 1 Inpatien  27. Manner Death 1  Actival 5 Pending Investigation 3 Suicide 6 Could not be determined   | ot 2 ER/Outpatier  Year) 28b. Time of Injury  ry - At home, farm, str  | nt 3 DOA Oth f 28c. Injun Worl M 1   | 26. Place of Death er: 4 \( \to \) Nursing Hom y at k? Yes 2 \( \to \) No  | 24a. Was a autops perform 1 Yes (Check only on the 5 Paside 8d. Describe house)  | 24b. Were at prior to death? 2 No 1 Yes  | obably 4 Unknown utopsy findings available completion of cause of 2 No                                    |
| ō                   | Physician: The law requi<br>this certificate has been s<br>ral director, page 2 should  | ertification; To Be Completed          | examiner?  1 Yes 2 No  Hospital: 1 Inpatien  27. Manne of Death 1 Natural 5 Pending Investigation 2 Accident Investigation   | ot 2 ER/Outpatier  Year) 28b. Time of Injury  ry - At home, farm, str  | nt 3 DOA Oth f 28c. Injun Worl M 1   | 26. Place of Death er: 4 \( \to \) Nursing Hom y at k? Yes 2 \( \to \) No  | 24a. Was a autops perform 1 Yes (Check only on the 5 PReside 8d. Describe ho   | 24b. Were at prior to death? 2 No 1 Yes  | obably 4 Unknown utopsy findings available completion of cause of 2 No                                    |
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| ō                   | sician: The law requi<br>certificate has been s<br>rector, page 2 should  | ertification; To Be Completed          | examiner?  1 Yes 2 No  Hospital: 1 Inpatien  27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide  4 Homicide  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state | nt 2 □ ER/Outpatier  Year) 28b. Time of Injury  ry - At home, farm, str. (Specify)  f my knowledge, deatt examination and/or in  | nt 3 DOA Cth f 28c. Injun Wor M 1 creet, factory, office h occurred at the tim vestigation, in my of | 26. Place of Death er: 4 Nursing Hom y at k? Yes 2 No 2 ne, date and place, a pinion, death occurre  | 24a. Was a autops perform 1 Yes (Check only on the 5 Reside 8d. Describe how the control of the  | 24b. Were at prior to death? 2 (a) No death? 1 (b) Yes  2 (a) No death? 1 (b) Yes  2 (a) No death? 1 (b) Yes  2 (a) No death? 2 (a) No death? 2 (a) No death? 2 (a) No death? 2 (a) No death? 2 (a) No death? 3 (b) No death? 4 (b) No death? 5 (a) No death? 5 (a) No death? 6 (b) No death? 6 (c) No death? 6 (d) No death? 7 (d) No death. 7 (d) No death.  | utopsy findings available completion of cause of 2 No Crify)  ural Route Number,  stated. to the cause(s) |
| ō                   | Physician: The law requi<br>this certificate has been s<br>ral director, page 2 should  | edical Certiflcation; To Be Completed  | examiner?    Yes   2 No   Hospital: 1   Inpatien   | nt 2 □ ER/Outpatier  Year) 28b. Time of Injury  ry - At home, farm, str. (Specify)  f my knowledge, deatt examination and/or in  | nt 3 DOA Cth f 28c. Injun Wor M 1 creet, factory, office h occurred at the tim vestigation, in my of | 26. Place of Death er: 4 \( \to \) Nursing Hom y at k? Yes 2 \( \to \) No  2 ne, date and place, a pinion, death occurre   | 24a. Was a autops perform 1 Yes (Check only on the 5 Reside 8d. Describe how the control of the  | 24b. Were at prior to death? 2 (a) No 1 (b) Yes  2 (a) No 1 (c) Yes  24b. Were at prior to death? 1 (c) Yes  24c. Were at prior to death? 1 (c) Yes  24c. Were at prior to death? 1 (c) Yes  24b. Were at prior to death? 1 (c) Yes  24b. Were at prior to death? 1 (c) Yes  24c. Were at prior to death. 1 (c) Yes  24c. Were at prior to death. 1 (c) Yes  24c. Were at prior to death. 1 (c) Yes  24c. Were at prior to death. 1 (c) Yes  24c. Were at prior to death. 1 (c) Yes  24c. Were at prior to death. 1 (c) Yes  24c. Were at prio | utopsy findings available completion of cause of 2 No Crify)  ural Route Number,  stated. to the cause(s) |
| ō                   | Physician: The law requi<br>this certificate has been s<br>ral director, page 2 should  | edical Certiflcation; To Be Completed  | examiner?  1   | ot 2 EP/Outpatier  Year) 28b. Time of Injury  ry - At home, farm, str (Specify)  f my knowledge, deatt examination and/or inced.   | reet, factory, office  h occurred at the tinvestigation, in my o                                     | 26. Place of Death er: 4  Nursing Hom yat k? Yes 2  No 2 ne, date and place, a pinion, death occurre e number  | 24a. Was a autops perform 1 Yes (Check only on the 5 Preside 8d. Describe how the card at the time, dispersion of the card at the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at  | 24b. Were at prior to death? 2 E No 1 Yes  Pence 6 Other (Spe)  Preet and Number or Run, State)  ause(s) and manner as at and place, and due  9d. Date signed (Monta)  | utopsy findings available completion of cause of 2 No Crify)  ural Route Number,  stated. to the cause(s) |
| ō                   | Physician: The law requi<br>this certificate has been s<br>ral director, page 2 should  | Medical Certification: To Be Completed | examiner?  1 Yes 2 No  27. Manner Death 1 Natural 2 Accident 3 Suicide 4 Homicide  1 Cortifying Physician: To the best of and manner state  29b. Signature and title of certifier  | The street of th | reet, factory, office  h occurred at the tinvestigation, in my o                                     | 26. Place of Death er: 4  Nursing Hom yat k? Yes 2  No 2 ne, date and place, a pinion, death occurre e number  | 24a. Was a autops perform 1 Yes (Check only on the 5 Preside 8d. Describe how the card at the time, dispersion of the card at the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at the time, dispersion of the card at  | 24b. Were at prior to death? 2 (a) No death? 1 (b) Yes  2 (a) No death? 1 (b) Yes  2 (a) No death? 1 (b) Yes  2 (a) No death? 2 (a) No death? 2 (a) No death? 2 (a) No death? 2 (a) No death? 2 (a) No death? 3 (b) No death? 4 (b) No death? 5 (a) No death? 5 (a) No death? 6 (b) No death? 6 (c) No death? 6 (d) No death? 7 (d) No death. 7 (d) No death.  | utopsy findings available completion of cause of 2 No Cify)  ural Route Number,  stated. to the cause(s)  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registre Amend Item #1 Per PHY G851 1 Par phi 6 at many of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 10:32 A M BETTY J. SPREULL Bettv J. Sprue11 December 12 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner DOCTORS COMMUNITY HOSPITAL PRINCE GEORGES LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□м ХХЕ Months Days Hours 12, 1938 NORTH CAROLINA Director 579 52 3935 67 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits an "natural", or items 23s or 28s-f show Medical Examinar must be notified at XX Yes 2 No Director PRINCE GEORGES BOWIE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be lifed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a eny injury or other traumatic event, Ite Medical Examinar mountaines. 12720 LODE STREET 20720 UNITED STATES Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2XXIo Specify: Specify: BLACK þ **¾**[XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coltege (1-4or 5+) GOVERNMENT (G.S.A.) CONTRACTING OFFICER 12TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CALLAS M. HARTSFIELD ဥ JAMES SHARPE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RIVERDALE, MD 20737 PHYLLIS SCOTT / DAUGHTER 6211 KENNEDY ST. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 17 DEC 2005 BRENTWOOD, MD 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME OF MARYLAND, INC. 21. Signature of Funeral Service Licensee larex 4308 SUITLAND ROAD SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes TNo 9 ☐ Unknown n signed by the Tabe de Tabe Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No YN Probably 4 ☐ Unknown CORONARY ARTERY DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an HYPERTENSION rector, page 2 s PULMONARY HYPERTENSION 1 ☐ Yes XX No or Attending Physicien: After this certific tuneral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 - Nursing Home 5 - Residence 6 - Other (Specify) 2 1 ☐ Yes XX No 1 Inpatient 2XER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred XX Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) I in by t 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Tuananh Vu

State Registrar

Spruell

31. Date filed (Month, Day, Year)
DEC 1 6 2005
Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vananh

MO

MO

000 55697

DOCTORS COMMUNITY HOSPTIAL

LANHAM, MD

|              |   | •              | 1 - For<br>State<br>Registrar  | State of Ma   |                              |                         | ent of He<br>ate of D           |                             | nd Mei                 |                                | jiene<br>leg. No.           | 05                              | 42407   |
|--------------|---|----------------|--|---|------------------------------|-------------------------|---------------------------------|-----------------------------|------------------------|--------------------------------|-----------------------------|---------------------------------|---|
| ı            | Physici   |                | Decedent's Name (First, Middle, Last)     William Ludwig   |   |                              |                         |                                 |                             |                        | Date of Dea<br>Month<br>ECEMbe | _                           | 2005                            | 3. Time of Death 1:42PM M                     |
| >            | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give  |   |                              | 4b. C                   | ity, Town, or                   |                             |                        |                                | 4c. Cou                     | nty of Death                    |   |
|              | Formul  |                | 1736 Trent St.  5. Social Security Number 6. Securi | x 7. Age  | (In yrs. last birtho         | fav) If Un              | Crof                            | ton<br>If Under 24          | 4 Hrs. 8               | Date of Birth                  |                             | Arun                            | idel place (State or Foreign                  |
|              | Funeral<br>Director   |                | 151-01-4397  | <b>X</b> M 2□F  | 93 Yr                        | Mont                    |                                 | Hours                       | Min.                   | (Month, Day<br>ecembe          | r 13,                       | 1911                            | Camden, NJ                                    |
|              | land<br>ow  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town o            | or Location             |                                 |                             |                        |                                |                             |                                 | 10d. Inside City Limits                       |
|              | e Man<br>3e-f sh  | Director       | Maryland Anne Aru  | ndel  |                              | Croft                   | con                             |                             |                        |                                |                             |                                 | 1 ⊠Yes 2 □ No                                 |
|              | with the or 20  | Dire           | 10e. Street and Number 1736 Trent St.  |   |                              | 10f.                    | Zip Code                        | 111                         |                        |                                | l0g. Citizen                |                                 | intry?  |
|              | death   | Funeral        | 1730 TEHE St.  | 12. Was Decedent E<br>Armed Forces?   | ver in U.S.                  | 13. Was De              |                                 | 114<br>spanic Origi         | in? (Specify           | y Yes or No-<br>an, etc.)      |                             | lace - Amer                     |   |
| 36           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic avant, the Medical Exertiner must be notified at once.  | by Fu          | 1 Never Married 2 Married 3 X Widowed 4 Divorced   | 1 ☐ Yes 2 📉 N<br>If Yes, Give<br>Year or Dates:   | 0                            |                         | s 2 <mark>X</mark> No           | Specify:                    | r deno nic             | an, etc.)                      | Spe                         | lack, White<br>c <i>ify:</i> Wh |   |
| 21215-0036   | 72 hou<br>natura  | eted I         | 15. Decedent's Edu<br>(Specify only highest grad   | cation  |                              |                         | Isual Occupa<br>work done di    |                             | of working             |                                | 16b. Kind of                |                                 |   |
| 121          | within<br>ane.<br>than "  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5-   |                              | fe. DO NO               | Tuse retired)<br>inistr         |                             | Si Working             |                                | Util:                       | i +                             |   |
|              | e filed<br>al Hygid<br>other<br>vant, I   | Be Co          | 17. Father's Name (First, Middle, Last)  |   |                              | ricin                   |                                 |                             | s Name (F              | irst, Middle,                  |                             |                                 |   |
| Maryland     | nould b<br>I Menta<br>narkad<br>natic a   | To             | William G. Schei   |   |                              |                         |                                 |                             | ra Ob                  |                                |                             |                                 |   |
| Z<br>Z       | nd 2 st<br>lith and<br>27 is n<br>r traun   |                | 19a. Informant's Name/Relationship (Ty<br>Robert Scheina / S   | on  |                              |                         | ess <i>(Str</i> eet a<br>ch Hil |                             |                        | oute <i>Numbe</i><br>ntrevi    |                             |                                 | p Code)<br>21617                              |
| Baltimore,   | of Hea<br>of Hea<br>if itam<br>or othe  |                | 20a. Method of Disposition  1 Deurial 2 Cremation 3 De   |   | 20b. Place of D<br>cemetery, |                         |                                 |                             | Date                   |                                | 20c. Locatio                |                                 |   |
| Ĕ            | it. Pag<br>rtment<br>rtant: I   |                | *4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens   |   | St. Ste                      | de.                     |                                 |                             | 2/21/                  |                                | Crown                       |                                 | e, MD.  |
| Ba           | Department |                | C. Signature of Purieral Service Licens  | Porus   | ell                          |                         | and Address                     |                             |                        | l Fune<br>Bowie                | eral Ho                     | ome<br>2071                     | 15  |
|              |   |                | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of  | ications that caused<br>ne cause on each lin  | the death. Do not            |                         |                                 |                             |                        |                                |                             |                                 | Approximate<br>Interval Between               |
|              | Physician /<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)  | w.,   | Artery a consequence of)     |                         | se,Uns                          | table                       | Angi                   | na                             |                             | _                               | Onset and Death                               |
|              | Examiner  |                | Sequentially liet conditions   | . Peripher  |                              |                         | isease                          |                             |                        |                                |                             |                                 | 10 yr.  |
|              | led<br>Isit   | niner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as a   | consequence of)              | :                       |                                 |                             |                        |                                |                             |                                 |   |
| ó            | execut<br>an and<br>rial-tran   | Examiner       | that initiated events<br>resulting in death) Last  | •   | consequence of)              |                         |                                 |                             |                        |                                |                             |                                 |   |
| 68760,       | ificate be executed<br>g physician and<br>as the burial-transit   | edicai         |  | Hypercho  | lesterol                     | emia                    |                                 |                             |                        |                                |                             |                                 |   |
| Box 6        | +- 2, 10  |                | IF FEMALE: 23b. Was decedent pregnant  | 23c. If yes, outcome  |                              |                         |                                 |                             |                        |                                | 23d. I                      | Date of delik                   | rerv  |
| .O.          | 0 0 0   | Physician/M    | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  | 1 Live birth  4 Pregnant at  9 Unknown  |                              | 3 ☐Ectopii<br>5 ☐ Other | c pregnancy<br>(specify)        |                             |                        |                                | 1                           | Month                           | Day Year                                      |
| <u>α</u>     | The law requires that the ste has been signed by th bage 2 should be detache  | y Phy          | Part II. Other significant conditions con  | ntributing to death bu  | it not resulting in th       | ne underlyin            | g cause give                    | n in Part I.                |                        | 23e. Did to                    | bacco use co                | ontribute to                    | the cause of death?                           |
| ords,        | w requires<br>been sign<br>should be  | ed by          |  |   |                              |                         |                                 |                             | _                      | 1 □ Y                          | es 2□No                     | 3 ☐ Pro                         | babiy 4 Nnknown                               |
| Vital Record | e law re<br>has be  | Completed      |  |   |                              |                         |                                 |                             | [                      | 24a. Was a autops              | SV                          | prior to co                     | opsy findings available ompletion of cause of |
| talF         |   | 0              | 25. Was case referred to medical   |   |                              |                         |                                 | 26 Place o                  | of Death (C            |                                | 2 No                        | death?                          | 2 □ No  |
| ž<br>Š       | Physician:<br>this certific<br>ral director,  | To B           | TES ZENO   |   | nt 2 ER/Outpa                | atient 3                | DOA Othe                        | _                           |                        | 5 Reside                       |                             | Other (Speci                    | fy)   |
| Division of  | ding P.<br>h.<br>After t  | tion;          | 27. Manne of Death  1 atural 5 Pending 2 Accident investigation  | 28a. Date of Injur<br>(Month, Day   | y 28b. Tim<br>Year) Inju     |                         | 28c. Injury<br>Work             | at<br>?<br>′es 2 ∐ No       |                        | . Describe h                   | ow injury occ               | urred                           |   |
| Visi         | r Attanding<br>er death.<br>ractor: After<br>by the funer   | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Inju-<br>building, etc  | ry - At home, farm           |                         |                                 |                             |                        | Location (Si                   | reet and Nu                 | mber or Rui                     | al Route Number,                              |
| ۵            | Hospitel or<br>24 hours afte<br>Funarel Dir<br>tely filled in   |                | 29a. Certifier 1 Certifying Phy  | 1   |                              | faath assum             |                                 |                             | -1                     |                                |                             |                                 |   |
|              | To the Hospitel or Attanding Phwithin 24 hours after death.  To tha Funarel Diractor: After the completely filled in by the funeral   | edical         | (Check only 2 Medical Exemi  | sician: To the best of<br>ner: On the basis of<br>and manner sta  | examination and/             | or investigat           | ion, in my op                   | e, date and<br>inion, death | place, and<br>occurred | at the time, d                 | ause(s) and<br>ate and plac | e, and due                      | stated.<br>to the cause(s)                    |
|              | To the within 2 To the complete   | M              | 29b. Signature and title of certifier  | 1///  | 1 1                          |                         | 29c. License                    |                             | (/3                    | 2                              | 9d. Date sig                | ned (Month,                     | Day, Year)                                    |
| 0            | 18  |                | 30. Name and address of person who co  | ompleted cause of de  | eath (Item 23a) (TV          | (pe, Print)             | 100                             | 0184                        | 50                     |                                | Dec.                        | 14, 2                           | 005   |
|              | 0   |                | Ronald C. Sroka, M   | 1.D. 168  | 4 Villag                     |                         | en C                            | rofto                       | n, MD                  | . 211                          | 14                          | ·                               |   |
|              | Sta<br>Registi  |                | 31. Date filed (Month, Day, Year)  DEC 1 6 2005  |   | r's Signature                | and a                   |                                 |                             |                        |                                |                             |                                 |   |
|              |   |                | PFO I 0 \$003  | ALCOHOL: STATE OF THE PARTY OF |                              |                         |                                 |                             |                        |                                |                             |                                 |   |

|   |                  | for State   | State of M  | aryland / Depa                       | artment of I                               | Health an                           |                                  | giene                                   | 0.05                                | 42408                               |
|---|------------------|---|---|--------------------------------------|--|-------------------------------------|----------------------------------|---|-------------------------------------|-------------------------------------|
|   |                  | Registrar  1. Decedent's Name (First, Midd)   | Vo. Lord  | Ce                                   | rtificate of                               | Death                               | 2. Date of De                    | Reg. No.                                | 000                                 |                                     |
| Physicia  | an               |   |   |                                      |  |                                     | Month                            | Day                                     |                                     | 3. Time of Death                    |
| /Medic  |                  | Charlotte C  4a. Facility Name (If not institution  | S. Smith  |                                      | 4b. City, Town, o                          | or Location of D                    |                                  |   | 2, 2005<br>County of Deat           | 1:00 A M                            |
| Examin  | er               |   |   |                                      |  |                                     | dati                             |   |                                     |                                     |
| Funeral   |                  | Washington Adv 5. Social Security Number  |   | e (In yrs. last birthday)            |  | If Under 24                         |                                  | rth                                     | ntgomer                             | hplace (State or Foreign            |
| Director  |                  | 579-52-2038   | 1 □ M 2 <b>X2X</b> =  | 66 Yrs.                              | Months Days                                | Hours N                             | Min. (Month, Da<br>12/31/        | 1938                                    |                                     | nington, DC                         |
| pr ,  |                  | Usual Residence of Decedent   |   | 140 00 7                             |  |                                     |                                  |   |                                     |                                     |
| anylai<br>ehow  | _                | 10a. State 10b. County  | y   | 10c. City, Town or Li                |  |                                     |                                  |   |                                     | 10d. Inside City Limits             |
| Ba-f  | ectc             | DC  |   | Washingt                             |  |                                     |                                  |   |                                     | 1 ☐ Yes 2 ☐ No                      |
| with ti   | 2                | 10e. Street and Number  |   |                                      | 10f. Zip Code                              | _                                   |                                  | _                                       | izen of What Co                     | ountry?                             |
| a 23  | Funeral Director | 1907 Maryland A   | IVe. NE   | Everin II C 12                       | 20002                                      |                                     | ? (Specify Yes or No             |   | .S.A.<br>14. Race - Ame             | ricon Indian                        |
| item<br>item  | 'n               | 11. Marital Status 1 □ Never Married 2 □ Mar  | Armed Forces?   |                                      | If Yes, specify Cub                        | oan, Mexican, P                     | uerto Rican, etc.)               | 0-                                      | Black, Whit                         |                                     |
| ors af  | by !             | 3 X Widowed 4 □ Divorce   | If Yes Give   |                                      | 1 ☐ Yes 2 🔀 No                             | Specify:                            |                                  |   | Specify: R1:                        | ack                                 |
| 2 ho  | ted              | 15. Deceder   | nt's Education  | 16a. Dece                            | dent's Usual Occu                          | pation                              |                                  | 16b. Ki                                 | ind of Business/                    |                                     |
| e.<br>en "r   | Completed        | Elementary/Secondary (0-12)   | est grade completed)  College (1-4or  | lite.                                | DO NOT use retire                          | ed)                                 | working                          |   |                                     |                                     |
| ed wi   | Con              | 12  |   | Vouc                                 | her Exar                                   | niner                               |                                  |   | S. Gove                             | rnment                              |
| d off   | Be               | 17. Father's Name (First, Middle,   | , Last)   |                                      |  |                                     | Name (First, Middle              |   | ,                                   |                                     |
| ould<br>Men<br>Marke  | 2                | Charles Hym   |   |                                      |  |                                     | ia L. Far                        |   |                                     |                                     |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or itema 23a or 28a-f show eny injury or other traumatic event, tra Mayleal Examiner must be notified at once. |                  | 19a. Informant's Name/Relation  |   |                                      | ng Address (Stree                          | t and Number o                      | r Rural Route Numb               | er, City o                              | or Town, State, 2                   | Zip Code)                           |
| tealth<br>tealth<br>sm 27   |                  | Priscilla Burr 20a. Method of Disposition   | <u>nett/Daughter</u>  |                                      |  |                                     | hington,                         |   | 0019<br>ocation - City or           | Taura Chaha                         |
| iges<br>or of b   |                  | 1 🛭 Burial 2 ☐ Cremation  |   | 20b. Place of Dispo<br>cemetery, cre | matory or other pla                        | ice)                                | Date                             | 200. LC                                 | ocation - City of                   | Town, State                         |
| t. Partmer  |                  | 4 Donation 5 Other (  |   | Fort Line                            | oln Ceme                                   | tery 12                             | /19/2005                         | Brei                                    | ntwood,                             | MD                                  |
| Depa<br>impo<br>eny ir  |                  | 21. Signature of Funeral Service  | SILICONS TO   |                                      |  |                                     | Fort Linc                        |   |                                     |                                     |
| 2 4   | 7                | 23a. Faryl. Enter the disease, o  | promplications that cause   |                                      |  |                                     | Rd. Brent                        | *************************************** | , MD 20                             | / ZZ<br>Approximate                 |
| Physician<br>/Medical   |                  | Sheck, or heart failure. Lis<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | st only one cause on each $\frac{1}{5}$                                     | ne.                                  | SHOC                                       |                                     | Side of respiratory to           |   |                                     | Interval Between<br>Onset and Death |
| Examiner  |                  | Conversion the line and distance  | CARI  | DIAC 1                               | ARRH                                       | YTH                                 | MIA                              |   |                                     |                                     |
| D #   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                    | Due to (or as   | a consequence of):                   |  |                                     |                                  | 1 2                                     | 1105                                |                                     |
| sician and burial-transit   | Examiner         | Cause (Disease or injury that initiated events  | · ACU   | TE RE                                | SPIRI                                      | TOR                                 | Y FA                             | 14                                      | UKE                                 |                                     |
| be exe  |                  | resulting in death) Last  |   | a consequence of):                   |  |                                     |                                  |   |                                     |                                     |
| ficate b<br>physic<br>s the b   | Ical             |   | d. DICO   | BITI                                 | ULC  | EK                                  | >                                |   |                                     |                                     |
| ding p  | Me               | IF FEMALE:  | 222 14  |                                      |  |                                     |                                  |   |                                     |                                     |
| leath certific<br>attending p   | Physiclan/Med    | 23b. Was decedent pregnant in the past 12 months?   |   | 2 Fetal death 3                      | Ectopic pregnand                           | у                                   |                                  |   | 23d. Date of del<br>Month           | ivery<br>Day Year                   |
| the de  | ysic             | 1 ☐ Yes 2 2 No<br>9 ☐ Unknown   | 4□Pregnant a<br>9□Unknown   | t time of death 5 t                  | Other (specify) _                          | -                                   |                                  |   |                                     |                                     |
| res that the de<br>signed by the a<br>l be detached t   | ď                | Part II. Other significant condit   | tions contributing to death t   | out not resulting in the u           | inderlying cause gi                        | ven in Part I.                      | 23e. Did                         | tobacco u                               | use contribute to                   | the cause of death?                 |
| uires<br>sign<br>Id be  | d by             |   |   |                                      |  |                                     | 1 🗆                              | Yes 2                                   | No 3□Pr                             | obably 4 Dünknown                   |
| w require<br>been si<br>should  | lete             |   |   |                                      |  |                                     | 24a. Was                         | an .                                    | 24h Were au                         | Itopsy findings available           |
| sician: The law<br>certificate has l<br>irector, page 2 s   | Completed        |   |   |                                      |  |                                     | - auto                           |   | prior to death?                     | completion of cause of              |
| sician:<br>certific<br>rector,  | Be               | 25. Was case referred to medical examiner?  | Hospital:   |                                      | _ 0:                                       | L                                   | Death (Check only                |   |                                     |                                     |
| Phys<br>rthis<br>raidi  | 5                | 1 ☐ Yes Şt XNo  | 28a. Date of Inju   | ury 28b. Time o                      | III JUDON                                  | 4 🗀 INUISII                         | ng Home 5 ☐ Res<br>28d. Describe |   |                                     | cify)                               |
| ding<br>th.<br>Afte   | tlon             | Natural 5 ☐ Pend  |   | iy Year) Injury                      | Wo   | ork?<br>]Yes 2 □ No                 | 200. 200000                      | ow mydd                                 | ry coounta                          |                                     |
| Atten<br>deal<br>octor;<br>y the  | fica             | 3 ☐ Suicide 6 ☐ Could   | not be 28e. Place of In   | jury - At home, farm, st             |  |                                     | 28f. Location                    | (Street an                              | nd Number or Ri                     | ural Route Number,                  |
| alor<br>safte<br>I Dire   | Certification:   | 4 Homicide  | building, e   | ic. (Specify)                        |  |                                     | City or To                       | wп, State                               | <del>)</del> )                      |                                     |
| To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the    | edical C         | 29a. Certifier 1 X Certify (Check only 2 Medica   | ing Physician: To the best<br>Il Examiner: On the basis of<br>and manner si | of examination and/or in             | th occurred at the to<br>estigation, in my | ime, date and p<br>opinion, death o | place, and due to the            | cause(s)<br>date and                    | ) and manner as<br>d place, and due | stated. to the cause(s)             |
| Fo thin roundly compli  | Me               | 29b. Signature and title of certifi   | -   | 1                                    |  | se number                           |                                  | 29d. Da                                 | te signed (Mont                     | h, Day, Year)                       |
| . 7 - 0   |                  | > Chaudha   | Sellar Kas  | apati M                              | CM C.                                      | 528                                 | 55                               | 12                                      | 1-12                                | -2005                               |
| (2)   |                  | 30. Name and address of person  | n who completed cause of  | death (Item 23a) (Type               |  |                                     |                                  |   |                                     |                                     |
| (0)   |                  | Dr. Chandra Kar   | rapati 7600   | Carroll A                            | wa Tako                                    | ma nark                             | MD                               |   |                                     |                                     |

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)
PEC 1 5 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2005 **Physician** Month December 14, Burnita Louise Shelton 2:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Health & Rehab. Center Prince George's Millenium: Ft. Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 62 yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 XX 577-56-4681 Director February 6, 1943 Washington, DC Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "naturel", or Iteme 23a or 28a-f ehow It e Medical Examiner must be notified at Prince George's Ft. Washington 1 ☐ Yes 2XXNo Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12021 Livingston Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12th Clerk permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Important: If Item 27 is marked oth any liquy or other treumatic event 90cg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John L. Shelton Louise Brim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary S. Bernheisel / Sister 66 Sussex Drive Lewes, Delaware 19958 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Dec. 15, 2005 Kalas Crematory Edgewater, Maryland 21. Signatura of Funeral Service Li 22. Name and Address of Facility George F. Kolas Fineral Hine IA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lyterrive Metasta Physician /Medical nce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 2**X**No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA filled in by the funeral 28b. Time of 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After 1xxNatural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospitel o within 24 hours aff To the Funerei Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi Berwa MD 770001d Branch Avenue C-101 Clinton, Maryland 20735 . Registrar's Signature 31. Date filed (Month, Day, Year) State 1 5 2005 Registrar

|  | 1               | For<br>State<br>Registrar   | State of M  | laryland                    |                                      |   | of Health<br>of Death           | 1                       | R  | eg. Ne. 0 (                  | )5                           | 42410  |
|--|-----------------|---|---|-----------------------------|--------------------------------------|---|---------------------------------|-------------------------|--|------------------------------|------------------------------|--|
| Physici<br>/Medic  |                 | 1. Decedent's Name (First, Middle, Las<br>RONALD LEROY  |   |                             |                                      |   |                                 |                         | 2. Date of Dea<br>Month<br>Dec             | 2 <sup>Pay</sup> 2           | Ŏ°å′5                        | 3. Time of Death 12:45 PM                          |
| Examin   |                 | 4a. Facility Name (If not institution, give<br>Genesis Health   |   |                             | ines                                 |   | m, or Location<br>Easto         | n                       |  |                              | of Death<br>.lbot            |  |
| Funeral<br>Director  |                 | 217-70-0793   | V   | ge (In yrs. la<br><b>69</b> | st birthday)<br>Yrs.                 | If Under 1 Y<br>Months D                  | ear If Under<br>ays Hours       | Min.                    | 8. Date of Birth<br>Month, Day<br>NOV - 20 | ), Year 1936                 | 9. Birthpl                   | AGENIA   |
| e Maryland<br>a-f ehow   | ctor            | Usual Residence of Decedent  10a. State 10b. County  MD TAL   | вот   | 10c. City,                  | Town or Lo                           |   |                                 |                         |  |                              | 10                           | d. Inside City Limits Yes 2 No                     |
| with th  | Director        | 10e. Street and Number  |   |                             |                                      | 10f. Zip Co                               | <sup>de</sup> 21601             |                         | 1  | 0g. Citizen of V             |                              | •  |
| ING Z I Z I 3-0030 be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23e or 28e-f ehow event, the Medical Examinational technified at   | by Funeral      | 11. Marital Status  1X Never Married  2 Married  3 Widowed 4 Divorced   | 12. Was Deceden Armed Forces 1  Yes 2 X If Yes, Give Year or Dates: | ?<br>] No                   |                                      | Was Decedent<br>If Yes, specify           | of Hispanic Or<br>Cuban, Mexica | rigin? (Spean, Puerto F | cify Yes or No-<br>Rican, etc.)            |                              | e - America<br>k, White, e   |  |
| vithin 72 hours affere. then "natural; or the Wudfell Exemination or the Wu | Completed       | 15. Decedent's Ec<br>(Specify only highest gra<br>Elementary/Secondary (0-12)   | de completed) College (1-4or  | 5+)                         | (Give<br>life.                       | DO NOT use r                              | one during mo:<br>etired)       | st of workin            | ng   | 16b. Kind of Bu              | usiness/Ind                  | ustry  |
|  | Be              | 0 17. Father's Name (First, Middle, Last) ALDRIDGE F. SHIF  |   |                             | NEV                                  | ER WOR                                    | 18. Moth                        |                         | (First, Middle,                            | Maiden Sumam                 | ne)                          |  |
| Marylan<br>d 2 should be<br>th and Mental<br>th and marked<br>?7 is marked<br>traumatic ev   | 2               | 19a. Informant's Name/Relationship (  | Type, Print)  |                             |                                      |   | reet and Numb                   | er or Rural             | Route Number                               | r, City or Town,             | -                            | Code)  |
| Theal theal  |                 | BONNIE WRIGHT/SI  20a. Method of Disposition  1 Surial 2 Cremation 3  | Removal from State  | е се                        | ace of Dispo<br>metery, crei         | osition (Name o<br>matory or other        | of<br>r place)                  | Da                      | ate  | TLAND 21                     | City or Tov                  |  |
| Baltimore, permit, Pages 1 a Depirtment of Hea Important: If frem any injury or othe   |                 | * 4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer  | 1500  |                             | 22<br>F                              | ELLOWS                                    | ddress of Facil                 | ity<br>NBEIN            | 3/2005<br>  & NEWI                         | OXFORI<br>IAM FUNI           | ERAL 1                       |  |
| Physician<br>/Medical  |                 | 23a. Part1. Enter the disease, or com<br>sock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)       | plications that cause<br>one cause on ach<br>a                      | ed the death.               |                                      | ter the mode of                           | dying, such as                  | ON ST<br>s cardiác or   | FASTON,                                    | MD 216                       |                              | Approximate<br>Interval Between<br>Onset and Death |
| 8 7 60, zate be executed  system and the burial-transit  | dical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or Injury that initiated events resulting in death) Last | c. Ath  | s a conseque                | leno 533                             | y disa                                    | ase/                            |                         |  |                              | 0                            | years  |
| .C. BOX 681, the death certificate y the attending phy, ched for use as the  | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No  | 23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown               | 2 Fetal                     | death 3                              | ⊒Ectopic pregr<br>⊒ Dther <i>(speci</i> i |                                 |                         |  | 23d. Dat<br>Mo               | te of deliver                | r <b>y</b><br>Day Year                             |
| rdS, P.  | ed by P         | Part II. Other significant conditions of  | contributing to death   | puln.                       | lting in the u                       | Aiser                                     |                                 | l.                      |  | bacco use conti<br>es 2 □ No | ribute to the                | e cause of death?                                  |
| II HECOLOS  The law require tate has been signate page 2 should to   | Completed by    |   |   |                             |                                      |   |                                 |                         | 24a. Was a autops perfor                   | med?                         | Were autoportor to condeath? | sy findings available apletion of cause of         |
| VITAL Prician: The certificate rector, pag   | Be              | 25. Was case referred to medical examiner?  | Hospital:   |                             |                                      |   | Dthee -                         | /                       | (Check only or                             | 74                           |                              |  |
| LIVISION OT VITAL HECOFIAS,  To the Hospital or Attending Phyaician: The law requires to within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be  | atlon: To       | 1 Yes 2 No  27. Manner of Death Natural 5 Pending 2 Accident investigatio   | 28a. Date of In<br>(Month, D  |                             | ER/Outpatie<br>28b. Time o<br>Injury |   | Injury at Work?                 | 2                       |  | ence 6 Doth                  |                              | )  |
| UNIS ital or Atte irs after de ral Directo   | Certification:  | 3 Suicide 6 Could not be determined   | building,   | etc. (Specify               | )                                    |   |                                 | ļ.                      | City or Tow                                |                              |                              |  |
| the Hosp<br>in 24 hou<br>he Fune,<br>pletely fil   | Medical         |   | nysician: To the bes<br>niner: On the basis<br>and manners          | of examinati                |                                      | ivestigation, in                          | my opinion, de                  |                         | ed at the time, o                          | ate and place, a             | and due to                   | the cause(s)                                       |
| To 1<br>with<br>To 1   | Σ               | 29b. Signature and title of certifier   | Mh  | My                          |                                      |   | DZ5                             | 133                     |  | 9d. Date signed              | 22.4                         | Day, Year)   |
|  |                 | 30. Name and address of person who MICHALL CROW  31. Date filed (Month, Day, Year)  | SLEY MP   | death (Item                 | OD                                   | Print) UTCHM                              | ANS 1                           | LANC                    | E  | ASTON,                       | MD                           | 21601  |
| St   | ate             | DEC.  | 2 3 2905  | Allera                      | - 1                                  | · Ann                                     | A.                              |                         |  |                              |                              |  |

|                                       |   |                     | 1 - For<br>State<br>Registrar   | State of M   | aryland / í                   |                     | artment of I  | dealth .                  | and Me  | ental Hygie                                    | ene<br>. %. 0 0           | 5 42411  |
|---------------------------------------|---|---------------------|---|--|-------------------------------|---------------------|---|---------------------------|---|--|---------------------------|--|
| *                                     | Physici   |                     | 1. Decedent's Name (First, Middle, La<br>Katherine Louis  |  | 29                            | •                   | ·   |                           | ~   | 2. Date of Death<br>Month                      | Day le 2                  | Year 9:20 P M  |
|                                       | /Medic<br>Examir  |                     | 4a. Facility Name (If not institution, giv<br>Washington Coun   | e street and number)   |                               |                     | 4b. City, Town, o   |                           |   | 7007000  | 4c. County of Washi       | of Death   |
| ×.                                    | Funeral<br>Director   |                     | 3/9-42-/192   | ex 7.Ag<br>□M 2∏gF   | e (In yrs. last bii<br>71     | thday)<br>Yrs.      | If Under 1 Year<br>Months Days  | If Under<br>Hours         | Min.  | B. Date of Birth<br>(Month, Day, Y<br>L2/08/19 | (ear)<br>134              | Birthplace (State or Foreign Country)  DC  |
|                                       | Maryland<br>-f ehow   | tor                 | Usual Residence of Decedent  10a. State  10b. County  MD  Washing   | ton  | 10c. City, Tow<br>Hage        |                     |   |                           |   |  |                           | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No   |
|                                       | with the<br>is or 28a   | Direc               | 10e. Street and Number  9 Sturgis Drive   |  |                               |                     | 10f. Zip Code 2174  | 0                         |   | 100  | . Citizen of W            | /hat Country?  |
| 980                                   | be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itema 23a or 28a-f ehow event. I're Medical Evaridust medical event.                               | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates: |                               |                     | Was Decedent of I<br>If Yes, specify Cub<br>1 ☐ Yes 2 🙀 No            | dispanic Or<br>an, Mexica |   | fy Yes or No-<br>can, etc.)                    | 14. Race<br>Black         | American Indian,<br>k, White, etc.   |
| 21215-0036                            | filed within 72 ho<br>Hygiene.<br>ther then "natur<br>int, toe Medical  | Completed           | 15. Decedent's E<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>12  | de completed) College (1-4or   |                               | (Give<br>life.      | dent's Usual Occul<br>kind of work done<br>DO NOT use retire<br>nager | during mos<br>d)          |   |  | Food                      | siness/Industry Services   |
| Maryland                              |   | To Be               | 17. Father's Name (First, Middle, Last)<br>Louis (unk) Man  |  |                               |                     |   |                           |   | First, Middle, Ma<br>uise (un                  |                           | 9)   |
|                                       | ges 1 and 2 should<br>it of Health and Mer<br>if Item 27 is marke<br>or other traumatic   |                     | 19a. Informant's Name/Relationship (George C. Sakad   |  | n 19b                         | $^{1}1$             | ng Address <i>(Street</i><br>Spring L                                 | and Numb<br>ake B         | $^{	ext{	iny or } 	ext{	iny or } 	ext{	iny old}}_{1	ext{	iny old}}$ | NW, Por  | city or Town, S<br>t Char | State, Zip Code)<br>lotte, FL 33952  |
| Baltimore,                            | Pages 1 a<br>nent of Hez<br>nt: If Item<br>iry or othe  |                     | 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)   |  |                               |                     | sition (Name of<br>natory or other pla<br>ng Cremat                   | 1                         | Dat   | 1:0  |                           | City or Town, State  |
| Balti                                 | permit. Pages<br>Depertment of I<br>Important: If Ite<br>any injury or of   |                     | 21. Significant Funeral Service Cice  | Conut  | A                             | 22                  | . Name and Addre  | ss of Facili              | ty Gera   | ald N. M                                       | linnich                   | Funeral Home<br>, MD 21740   |
| · · · · · · · · · · · · · · · · · · · | Physician<br>/Medical<br>Examiner   | ılner               | 23a Part. Enforthe disease, or com shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | a. Pseuto<br>Due to (or as<br>Sep. Hi  | . /                           | <i>ာဇ်ာ</i><br>of): | er the mode of dyi  |                           |   | respiratory arrest                             |                           | Approximate interval Between Onset and Death One month                             |
| 8760,                                 | ate be executed hysicien and the burial-transit   | ilcal Examiner      | that initiated events<br>resulting in death) Last   | U.   | noma<br>esneupeznos a<br>tech | *                   | tive 4  | ng                        | Disc  | a se   |                           | Years  |
| P.O. Box 6                            | ath certific<br>attending p<br>for use as   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown           | 2 Fetal death                 |                     | Ectopic pregnanc Other (specify)                                      | /                         |   |  | 23d. Date<br>Mont         | o of delivery<br>th Day Year   |
|                                       | w requires that the de<br>been signed by the s<br>should be detached  | ρ                   | Part II. Dther significant conditions of Hypertens  | •  | ut not resulting in           | n the u             | nderlying cause gw  | en in Part I              | l.  |  |                           | bute to the cause of death?  3 Probably 4 Unknown                                  |
| II Reco                               | The law re<br>cete has bed<br>page 2 sho  | Completed           | Spinul C  | and tur  | now                           |                     |   |                           |   | 24a. Was an autopsy performe                   | g? de                     | fere autopsy findings available for to completion of cause of path?  Yes 2 \sum No |
| Vita                                  | Physician:<br>this certifice<br>ral director, I   | Be                  | 25. Was case referred to medical examiner?  1  Yes  | Hospital:  | a 🗆 50/0                      |                     |   |                           |   | Check only one                                 |                           |  |
| Division of Vital Records,            | To the Hospital or Attending Physician: The law within 24 hours after death, and the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 or property. | Certification: To   | 27. Manner of Death  1 Naturat 5 Pending 2 Accident investigation 3 Suicide 6 Could not be  | 28a. Date of Inju<br>(Month, Da  | y Year) I                     | Time of<br>njury    | 28c. Injui  | y at                      | No 286  | 5 Residence d. Describe how                    | intury occurre            |  |
| Ω                                     | Hospital or A<br>24 hours after<br>Funeral Dire<br>stely filled in by   |                     | 4 Homicide determined   | building, et   | c. (Specity)                  |                     |   |                           |   | City or Town, S                                | State)                    |  |
|                                       | the Hos<br>hin 24 ho<br>the Fun<br>npletely i   | Medical             | (Check only 2   Medical Exan  | ysician: To the best<br>niner: On the basis of<br>and manner sta                   | examination an                | d/or in             | estigation, in my o   | pinion, dea               | id place, and<br>ith occurred                                       | at the time, date                              | and place, ar             | nd due to the cause(s)   |
| )                                     | With Con  |                     | 29b. Signature and title of certifier   | 7  |                               |                     | 29c. Licens   |                           | 96  | De   | Cemb                      | (Month, Day, Year)  LL 18, 2005  |
| 5H                                    | -7  |                     | 30. Name and address of person who  | k ho   | 2031                          | (Туре,              | Cappar  | 13 R                      | 4 /3  | bonsbo   | so A                      | es 18,2005<br>10 21713   |
| \$ 2000<br>2000                       | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year)  IEC 19 2   |  | ar's Signature                | 1                   | ed .  |                           |   |  |                           |  |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year **Physician** Dec 8 2005 2220 Audrey Louise Stafford /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Calvert Memorial Hospital Prince Frederick Il Under 1 Year Il Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5 Social Security Number 6 Sex Days **Funeral** Months 1 □ M 2 □ F 218-24-2975 76 May 8 1929 North Carolin Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 23a or 28a-f show traumatic event, the Medical Examiner must be nutified at Port Republic 1 ☐ Yes 2 🔀 No Maryland Calvert Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20676 United States 3885 Broomes Island Road Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? iteme 1 ☐ Yes 2X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☐ No Specify. Specify: white Completed by 3 Widowed 4 Divorced Year or Dates: "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Florist Shop secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H tant: If itam 27 is marked oth Clarence H. Ingle Euna Corn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Alvin C. Stafford, Jr.-husbard 3885 Broomes Is. Rd. Port Republic MD 20676 other 20b. Place of Disposition (Name of cometery cramatory or other place) 9 2005

Metropolitan Funeral Service 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State ö Alexandria Virginia Department of Important: if any injury or 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ol dying, such as cardiac or respiratory arrest,
shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ( Mmil disease or condition resulting in death) /Medical (or as a consequence of) Examiner 1 menha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed pritte that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical the use as attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) by the 9 Unknown 9 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

About Flocilians Conditions Contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 TYes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA Certification: To After the 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending 1 Yes 2 No investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of gertifier 9 0006/94 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Mathur, M.D. 110 Hospital Rd. Suite 305 Prince FRederick MD 20678 32. Registra Signature 31. Date liled (Month, Day, Year) State Elmena, DEC 1 3 2005 Registrar

|             |   |                 | For<br>Stete<br>Registrar  |                           | State o  | f Marylan  | d / Depa                        | artment<br>rtificate            | of H                  | ealth a                   | and M                    | ental Hy                                    | giene<br>Reg. No.                  | 005                      | 421   | +13                         |
|-------------|---|-----------------|--|---------------------------|--|--|---------------------------------|---------------------------------|-----------------------|---------------------------|--------------------------|---|------------------------------------|--------------------------|---|-----------------------------|
|             | Physici   |                 | 1. Decedent's Name   |                           | , Last)<br>-EE   | SHI  | RKEY                            | <                               | SR.                   |                           |                          | 2. Date of D<br>Month<br>DECEMB             | Day                                | Yee 4 200                |   | of Death                    |
|             | /Medic<br>Examin  |                 | 4a. Facility Name (If  |                           |  |  | ,,,,,                           | 4b. City, T                     | own, or               | Location of               |                          | DECCI (D                                    |                                    | County of Di             |   |                             |
|             | _xamm   |                 | THE JOH  | NS H                      | OP KINS  | HOSPIT   | AL                              | RALTI                           | MOR                   | F CI                      | TY                       |   | NA                                 | )                        |   |                             |
|             | Funeral   |                 | 5. Social Security Nu  |                           | 6. Sex   | 7. Age (In yrs.                                    |                                 | If Under 1                      | Year                  | If Under                  | 24 Hrs.                  | 8. Date of B                                | irth                               | 9. 6                     | Birthplace (Sta.                                  | te or Foreign               |
|             | Director  |                 | 579-40-47  | 72                        | 1 <b>X</b> M 2□F                                       | 77   | Yrs.                            | Months                          | Days                  | Hours                     | Min.                     | (Month, D<br>DEC. 2                         | 7, 19:                             | 27 V                     | Country)  |                             |
|             | pu >  |                 | Usual Residence of I   |                           |  | 10° Cit  | Taura and                       |                                 |                       |                           |                          |   |                                    |                          | Tan i i   |                             |
|             | anyla<br>shov   | -               | Toa. State   | 10b. County               |  |  | ty, Town or Lo                  |                                 |                       |                           |                          |   |                                    |                          |   | City Limits es 2X No        |
|             | within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f show the Modical Exam not matter to invitibut at   | Director        | FL   | MANAT                     | EE   | PA   | LMETTO                          |                                 |                       | -1                        |                          |   |                                    |                          |   |                             |
|             | with t  | Dir             | 10e. Street and Num  |                           |  |  |                                 | 10f. Zip (                      |                       |                           |                          |   |                                    | en of What               | Country?  |                             |
|             | s 23  | Funeral         | 175 BIMIN  | I DRIV                    |  | dest Constall                                      | 6 10                            |                                 | 221                   |                           | -:-0/0                   | -7 - 1                                      | USA                                |                          |   |                             |
|             | Itam  | in.             | <ol> <li>Marital Status</li> <li>Never Marrie</li> </ol>   | d 2 Marri                 | Armed Fo   |  | .5.                             | If Yes, speci                   | fy Cuba               | n, Mexicar                | n, Puerto F              | cify Yes or N<br>Rican, etc.)               | 0-                                 | Black, W                 | merican Indi <i>a</i> n<br>hite, etc.             | ,                           |
| 36          | urs af  | by F            | 3 Widowed 4  |                           | If Yes, Giv<br>Year or D                               | 9  |                                 | 1 Yes 2                         | X No                  | Specify:                  |                          |   | 5                                  | Specify:                 | WHITE   |                             |
| 21215-0036  | 2 hou   |                 |  | 15. Decedent              | 's Education   |  | 16a. Dece                       | dent's Usual                    | Occupa                | ition                     |                          |   | 16b. Kin                           | d of Busine              | ss/Industry                                       |                             |
| 215         | nin 7.<br>In "in  | Completed       | (Specification (Speci |                           | t grade completed)  College (1                         | -4or 5+)   | (Give                           | kind of work<br>DO NOT use      | done d<br>retired,    | luring mos<br>)           | t of workir              | g   |                                    |                          | ,   |                             |
| 21          | d with  | E O             | 12   | outy (0 12)               | College (1   | -401 3+)   | MAIN                            | TENANO                          | CE                    |                           |                          |   | U.S.                               | POST                     | AL SERV   | /ICE                        |
| Þ           | e file<br>othe<br>vant,   | Be C            | 17. Father's Name (F   | First, Middle, I          | ast)   |  |                                 |                                 |                       | 18. Mothe                 | er's Name                | (First, Middle                              | e, Maiden S                        | iumame)                  |   |                             |
| lar         | uld by<br>Aenta<br>rkad<br>tic a  | To E            | DORMAN SH  | IRKEY                     |  |  |                                 |                                 |                       | URSU                      | ULA D                    | ERROW                                       |                                    |                          |   |                             |
| Maryland    | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23e or 28a-f show any injury or other traumatic avant, the Medical Exam and mark to indiffer at one. |                 | 19a. Informant's Nar   | ne/Relationsh             | nip (Type, Print)                                      |  | 19b. Mailie                     | ng Address (                    | Street a              | ind Numbe                 | er or Rura               | Route Numl                                  | ber, City or                       | Town, State              | a, Zip Code)                                      |                             |
|             | alth alth 27 i  |                 | MARIAN G.  | SHIRK                     | EY/WIFE  |  | 175                             | BIMIN                           | I DR                  | IVE,                      | PALM                     | ETTO,                                       | FL 3                               | 4221                     |   |                             |
| re          | of He<br>Itam   | Ш               | 20a. Method of Dispo   |                           |  |  | Place of Dispo                  | matory or oth                   | ner niare             | 9)                        | D                        | ate   | 20c. Loc                           | ation - City             | or Town, State                                    |                             |
| E           | Page<br>nent<br>int: If   |                 | 1 ☐ Burial 2 🔼   |                           | 3 □Removal from :<br>necify)                           | State CHE  | SAPEAR<br>TER, I                | E CRE                           | MATI                  | ON                        | 2/15                     | /2005                                       | STE                                | VENSV                    | ILLE, M   | D                           |
| Baltimore,  | mit.<br>Partn<br>Sorta<br>7 nju   |                 | 21. Signature Fun  | Graf Service              | icensee/   | 7/   | 22                              | 2. Name and                     | Addres                | s of Facilit              | ty                       |   |                                    |                          |   |                             |
| m           | Departing any r   |                 | 16   | VY.                       | 4/   | لسا  | F                               | ELLOWS<br>06 SHA                | S, H<br>AMRO          | ELFEN<br>CK RO            | NBEIN<br>DAD.            | & NEW<br>CHESTE                             | NAM F<br>R. MD                     | UNERA<br>216             | L HOME,<br>19                                     | P.A.                        |
|             | Pnysician   |                 | 23a. Part1. Enter the<br>shock, or heart<br>Immediate Cause (F<br>disease or condition<br>resulting in death)  | failure. List (<br>Final  | complications that conly one cause on e                | aused the deat<br>ach line.                        | h. Do not ent                   | er the mode                     | of dying              | g, such as                |                          | respiratory a                               |                                    |                          | Approxin<br>Interval I<br>Onset ar                | nate<br>Between<br>nd Death |
| 68760,      | The law requires that the death certificate be executed as the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | dical Examiner  | Sequentially list con if any, leading to litricause. Enter Under Cause (Disease or in that initiated events resulting in death) La   | hediate<br>lying<br>njury | b. NON<br>Due to (                                     | or as a conseq<br>or as a conseq<br>or as a conseq | LL CE uence of).                | LL L                            | UNG                   | i cA                      | NCE                      | R   |                                    |                          | THREE   | Nemile                      |
| .O. Box     | that the death certifi<br>led by the attending I<br>detached for use as   | by Physician/Me | IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 U 9 Unknown  | nonths?                   |  | irth 2  Feta<br>ant at time of d                   | Ideath 3                        | ]Ectopic pre<br>] Other (spe    |                       |                           |                          |   | 23                                 | id. Date of o            | delivery<br>Day                                   | Year                        |
| s, D        | w requires that<br>been signed b<br>should be deta  | ed by Pł        | Part II. Other signific  | cant conditio             | ns contributing to de                                  | eath but not res                                   | ulting in the u                 | nderlying car                   | use give              | n in Part I.              |                          |   | tobacco use                        | ,                        | to the cause of                                   |                             |
| I Record    |   | Completed       |  |                           |  |  |                                 |                                 |                       |                           |                          | 24a. Was<br>auto<br>perf<br>1 \( \text{Yes} | ormed?                             | prior t<br>death         | autopsy finding<br>o completion o<br>?<br>es 2 No |                             |
| Vital       | Physician:<br>r this certific<br>ral director,  | Be              | 25. Was case referre examiner?   | ed to medical             |  |  |                                 |                                 | _                     |                           | of Death                 | (Check only                                 | one)                               |                          |   |                             |
|             | hysi<br>his c   | ပ္              | 1 ☐ Yes 2 Xî   | lo                        |  |  | ER/Outpatier                    | -                               | Othe                  | r: 4 □ Nu                 | rsing Hom                | e 5 ☐ Res                                   | idence 6                           | Other (Sp                | pecify)   |                             |
| n           | ng P<br>(fter t   | on:             | 27. Manner of Death  | 5 Pending                 | 28a. Date of (Mont                                     | of Injury<br>h, Day Year)                          | 28b. Time of<br>Injury          | 28                              | c. Injury<br>Work     | at<br>?                   | 2                        | 8d. Describe                                | how injury                         | occurred                 |   |                             |
| Sio         | ttandi<br>death.<br>tor: A  | cati            | 2 Accident   | investig                  | ation  |  |                                 | M                               | 1 🗆 Y                 | es 2 🗆 !                  | No                       |   |                                    |                          |   |                             |
| Division of | l or Attandatter deatl<br>Diractor:<br>I in by the  | Certification;  | 3 ☐ Suicide<br>4 ☐ Homicide  | determi                   | ned 286. Place   | of Injury - At hong, etc. (Specify                 | ome, farm, str                  | eet, factory,                   | office                |                           | 2                        |   | (Street and wn, State)             | Number or                | Rural Route N                                     | umber,                      |
|             | ital c  |                 |  | - 4                       | 1000   |  |                                 |                                 |                       |                           |                          |   |                                    |                          |   |                             |
|             | To the Hospital or Attending within 24 hours after death.  To the Funarel Director: After completely filled in by the fune  | edical          | (Check only 2<br>one)  | Medical E                 | g Physicien: To the<br>Exeminer: On the ba<br>and mann | sis of examina                                     | wledge, death<br>tion and/or in | n occurred at<br>vestigation, i | t the time<br>n my op | e, date an<br>inion, deat | d place, a<br>th occurre | nd due to the<br>d at the time,             | cause(s) a<br>, date <i>a</i> nd p | nd manner<br>lace, and d | as stated.<br>ue to the cause                     | e(s)                        |
|             | To To Com   | Σ               | 29b. Signature and   | itle of certifier         | 0. 11  | <b>1</b> .   |                                 | 29c.                            | License               | number                    |                          |   | 29d. Date                          | signed (Mo               | nth, Day, Year                                    | )                           |
|             |   |                 | May  | ulk                       | J. 141   | Meds   | - MT                            | R                               | ES                    | - (                       | 000                      |   | DECEM                              | BER                      | 14,20   | 005                         |
|             |   |                 | 30. Name and address   | ss of person V            | vho complete o us                                      | e of death (Item                                   | n 23a) (Type,                   |                                 |                       |                           |                          |   | 11111111                           |                          | , , ,   |                             |
|             |   |                 | MAULIK   |                           | JMUDAR   | 600  | NORTH                           | WOLFE                           | F_5'                  | TREE:                     | T Bi                     | ALTIMO                                      | RE                                 | MD                       | 2128  | 7                           |
|             | Sta<br>Registr  |                 | 31. Date filed (Month  | DEC                       | 1 4 2005 b   | egistra 's Signa                                   | ture #                          | Apres                           | as                    |                           |                          |   |                                    |                          |   |                             |

|  |   | 1 - For<br>State<br>Registrar  |  | State of I   |  | Ce  | rtificate o  |  | h  |  | Reg. No:   | UU   | ) !   | 1641  |
|--|---|--|--|--|--|---|--|--|--|--|--|--|---|---|
| Physic   | ian   | Decedent's Name     AWYENCE  | Eirst, Middle, La<br>Strople   | st)  |  |   |  |  |  | <ol><li>Date of Dea<br/>Month</li></ol>  | ath<br>Day   | Ye   | ar  | 3. Time of Dear   |
| /Medi  |   | Lawre  | nee  | Emery  |  | Str   | ople, Ji   | r  |  | ecembe   |  | 5 20   |   | 0101  |
| Exami  | ner   | 4a. Facility Name (II  |  |  |  |   | 4b. City, Town   |  | on of Death  |  |  | County of [  |   |   |
|  |   | 5. Social Security N   |  | nal Medic  | Age (In yrs.   |   | Salis  |  | ler 24 Hrs.  | 2 Date of Birt   |  | icomi  |   | o /State or For   |
| Funeral<br>Director  |   | 146-60-9 Usual Residence of  | 077  | 9X<br>M 2□F  | 40   | Yrs.  | Months Day   |  | s Min.   | B. Date of Birt<br>(Month, Da<br>10-15-  |  |  |   | e (State or For<br>)<br>Jersey  |
| tal Hygiene.<br>d other than "natural", or itema 23a or 28e-f show<br>event, tra Madical Examinar must be notified at  | ō   | 10a. State   | 10b. County  |  | ·  | y, Town or Lo   |  |  |  |  |  |  | 10d   | . Inside City Lir   |
| 280  | ect   | MD<br>10e. Street and Nur  | Somerse  | t  | P  | rinces  | s Anne   | le   |  |  | 10a, Citi  | zen of Wha   | t Country   | ?   |
| P 0  | Funeral Director  |  |  | 113 C+-  |  |   |  |  |  |  |  |  | ,   |   |
| 78 23  | era   | 11. Marital Status   | inces wi   | 11iam St   | ent Ever in U  | S. 13.  | Was Decedent of Yes, specify C   | 853<br>of Hispanic   | Origin? (Spec  | ify Yes or No  |  | USA<br>14. Race - A  | American  | Indian,   |
| 흔  | 표   |  | ied 2 Married  | Armed Force 1 Tes 2 If Yes, Give   | es?.<br>No   |   | N  |  |  | ican, etc.)  |  | Black, \   | White, etc  |   |
| Eval.  | Ď   | 3 Widowed  | 4 Divorced   | If Yes, Give Vear or Date  | os:  |   | 1 □ Yes 2001   | No Spec  | rty:   |  |  | Specify:   | Whit  | e   |
| retur  | ted   | (Spec  | 15. Decedent's E   | ducation   |  |   | dent's Usual Oc  |  | ost of working   | a  | 16b. Ki  | nd of Busin  |   |   |
| en in  | pie   | Elementary/Seco  |  | College (1-4   | or 5+)   | life.   | DO NOT use rea   | tired)   |  |  |  |  |   |   |
| ygien<br>t, the  | Completed   | 9  |  | none   |  | Carp  | enter  |  |  |  |  | struc  | ction   | 1   |
| d oth  | Be  | 17. Father's Name  |  |  |  |   |  | 18. Mc   | other's Name   | (First, Middle,  | Maiden   | Sumame)  |   |   |
| Men  | P   |  |  | Strople,   | Sr.  |   |  |  | nne Hov  |  |  |  |   |   |
| f Health and Mental Hygiene.<br>Item 27 is marked other than "natural", other treumatic event, the Madical Exa   |   | 19a. Informant's Na  |  |  |  | 0   | ing Address (Stre  |  |  |  |  |  |   | ode)  |
| healt  |   | 20a. Method of Disg  | ward/Sis   | ter  | 20h P  |   | Upper H:   |  | bad, we  |  |  | cation - Cit   |   | State   |
| or or  |   | 1 🗆 Burial 2   | Cremation 3  | Removal from Sta   | ate c  | emetery, cre  | matory or other p  | place)   | 1  |  |  |  |   |   |
| Depertment of Important: If its eny injury or o once.  |   |  | 5 Other (Special   |  | Sa   |   | y Crema  |  |  | /2005  | Sal  | isbury   | y , Ma  | aryland   |
| Depe<br>Impo   | 1   | Signature of Fu  | ineral <del>Service</del> (ICe   | nsee   |  | Á   | 2. Name and Ad<br>linman F   | unera  | 1 Home   |  |  |  |   |   |
|  |   | 2 Pari Falor   | 2 Al   | Mun 1  | M00295   | 1   |  |  |  |  |  |  |   |   |
|  |   | shock or hea   |  | notionations that barrion  | And the deat   | Do not an   | 1673 So  | merse  | t_Ave.   | , Princ  | cess.  | Anne   |   |   |
|  |   | SHOOK, OF HOU  | rt failure. List only  | one cause on eac   | sed the death<br>h line.   | n. Do not en  | 1673 Son<br>ter the mode of t  | merse<br>dying, such   | t Ave.<br>as cardiac or  | Prince respiratory as  | cess.  | Anne   | A<br>In   | pproximate<br>iterval Betwee  |
| iysician   | 6   | nmediate Cause (   | (Final   | one cause on eac<br>a. Smoke Ir  |  |   | .1673 Sor  | merse<br>dying, such   | t Ave.<br>as cardiac or  | , Prince respiratory and   | cess.  | Anne   | A<br>In   | pproximate<br>iterval Betwee  |
| Medical  | 6   | omediate Cause   | (Final   | a. Smoke Ir  |  | n   | .1673 Son  | merse<br>dying, such   | t Ave.<br>as cardiac or  | , Prince respiratory and   | cess.  | Anne   | A<br>In   | pproximate<br>iterval Betwee  |
|  | -   | nmediate Cause (<br>isease or condition<br>resulting in death)   | (Final<br>on   | a. Smoke Ir  | nhalatio<br>as a conseq  | ON<br>uence of):  | .1673 Son  | merse<br>dying, such   | t Ave.<br>as cardiac or  | , Princ<br>respiratory a   | rest,  | Anne   | A<br>In   | pproximate<br>iterval Betwee  |
| Medical<br>kaminer   | niner   | imediate Cause (isease or condition resulting in death)  Sequentially list conditions, leading to the cause. Enter Under   | (Final on the state of the stat | a. Smoke Ir  | nhalatio   | ON<br>uence of):  | 1673 So:   | merse<br>dying, such   | t Ave .<br>as cardiac or   | , Princ  | rest,  | Anne   | A<br>In   | pproximate<br>iterval Betwee  |
| Medical<br>kaminer   | xaminer   | nmediate Cause (<br>isease or condition<br>resulting in death)   | nditions,  | a. Smoke Ir Due to (or b. Due to (or   | nhalation as a consequence as a consequence  | uence of):  | 1673 So  | merse<br>dying, such   | t Ave as cardiac or  | , Princ  | cess<br>rrest,   | Anne   | A<br>In   | pproximate<br>iterval Betwee  |
| Medical<br>kaminer   | Ä   | mediate Cause is is asset or condition resulting in death)  Sequentially list confiant, leading to make the cause. Enter Under Cause (Disease or that inflated events  | nditions,  | a. Smoke Ir Due to (or b. Due to (or   | nhalatio<br>as a conseq  | uence of):  | 1673 So  | merse<br>dying, such   | t Ave.<br>as cardiac or  | , Princ  | CESS<br>rrest,   | Anne   | A<br>In   | pproximate<br>iterval Betwee  |
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| Medical<br>kaminer   | Physician/Medical Ex  | ineadate Cause isease or condition resulting in death)  Sequentially list contains a cause. Enter Unde Cause (Disease or that infliated events resulting in death) in the past 12 1 Yes 2 1  | nditions, misdials shrying injury stast  | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco  | nhalation as a consequence of pregnatiat at time of driving and the consequence of the co | uence of):  uence of):  uence of):  uence of):  | □Ectopic pregna<br>□ Other (specify  | ancy   |  |  | 1  | 23d. Date o<br>Month   | A irr   | pproximate treval Batwae inset and Dea  |
| Medical<br>kaminer   | by Physician/Medical Ex                                       | isease or condition resulting in death)  Sequentially list conditions and the cause. Enter Under Cause (Disease or that initiated events resulting in death) light past 12 1 Yes 2 9 Unknown   | nditions, misdials shrying injury stast  | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco  | nhalation as a consequence of pregnatiat at time of driving and the consequence of the co | uence of):  uence of):  uence of):  uence of):  | □Ectopic pregna<br>□ Other (specify  | ancy   |  | 23e. Did t   | 1  | 23d. Date o<br>Month   | f defivery  | pproximate the value of the value of the value of death and Death |
| Medical<br>kaminer   | by Physician/Medical Ex                                       | isease or condition resulting in death)  Sequentially list conditions and the cause. Enter Under Cause (Disease or that initiated events resulting in death) light past 12 1 Yes 2 9 Unknown   | nditions, misdials shrying injury stast  | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco  | nhalation as a consequence of pregnatiat at time of driving and the consequence of the co | uence of):  uence of):  uence of):  uence of):  | □Ectopic pregna<br>□ Other (specify  | ancy   |  | 23e. Did t   | obacco u<br>Yes 2  | 23d. Date o<br>Month<br>ise contribu<br>□ No 3 [   | f defivery  | ay Yea  |
| Medical<br>kaminer   | by Physician/Medical Ex                                       | isease or condition resulting in death)  Sequentially list conditions and the cause. Enter Under Cause (Disease or that initiated events resulting in death) light and the cause (Disease or that initiated events and the cause (Disease or that initiated events and the cause (Disease or that initiated events are sulting in death) light and the cause of the  | nditions, misdials shrying injury stast  | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco  | nhalation as a consequence of pregnatiat at time of driving and the consequence of the co | uence of):  uence of):  uence of):  uence of):  | □Ectopic pregna<br>□ Other (specify  | ancy   |  | 23e. Did t   | obacco u<br>Yes 2{<br>an<br>osy<br>ormed?  | 23d. Date o Month use contribu No 3 [ 24b. Wer prio deg  | f defivery Dieste to the Probab   | ay Yea  |
| Medical<br>kaminer   | Completed by Physician/Medical Ex                             | inmediate Cause in isease or condition resulting in death)  Sequentially list containing to include Cause (Disease or that initiated events resulting in death) I  | inditions, multiplicate with the state of th | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco  | nhalation as a consequence of pregnatiat at time of driving and the consequence of the co | uence of):  uence of):  uence of):  uence of):  | □Ectopic pregna<br>□ Other (specify  | ancy<br>/)<br>given in Pa  | urt I.   | 23e. Did t<br>1 🗀 24a. Was<br>autoj<br>perid<br>1 A Yes  | obacco u<br>Yes 2{<br>an<br>psy<br>primed?<br>2 □ No   | 23d. Date o Month use contribu No 3 [ 24b. Wer prio deg  | f defivery Dieste to the Probab   | ay Yea  |
| Medical<br>kaminer   | Be Completed by Physician/Medical Ex                          | inediate Cause in isease or condition resufting in death)  Sequentially list condition in the cause. Enter Under Cause (Disease or that initiated events resulting in death) If FEMALE:  23b. Was deceden in the past 12 1 Yes 20 9 Unknown  Part II. Other significant in the cause of the cause o | nditions, misdate with the pregnant months?  | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d.  23c. If yes, outco 1  | nhalation as a consequence of pregnation at time of or or of | uence of):  uence of):  uence of):  uence of):  uence of):  utting in the u   | □Ectopic pregna □ Other (specify, underlying cause   | ancy<br>()<br>given in Pa<br>26. Pi  | urt I.   | 23e. Did t 1 1 24a. Was autor performed 1 1 Yes Check only of  | obacco u Yes 2{ an psy rrmed? 2 □ No   | 23d. Date o<br>Month<br>Isse contribu  | f defivery Dieste to the Probab re autops: r to comp th? Yes 2  | ay Yea  |
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| ath.  The state this cardicate has been signed by the attending physicien end in the state of th | Certification; To Be Completed by Physician/Medical Ex        | inmediate Cause in risease or condition resuffing in death)  Sequentially list contained the cause. Sequentially list contained the cause (Disease or that infliated events resulting in death) I limited events resulting in death) I li | inditions, minimized and in high grant months?  It pregnant months?  No  ficant conditions of the months of the mo | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1   | mhalation as a consequence of pregnation as a consequence of p | uence of):  uence | □Ectopic pregna □ Other (specify) underlying cause  ont 3□ DOA of 28c. In A M treet, factory, offi   | 26. Pl Other: 4 Injury at Work? 1   Yes 2  | ace of Death Nursing Hom 2:  \( \) \ | 23e. Did to the saturation of the control of the co | obacco u Yes 2{ an psy psy cone) dence ( how injur hous Street an wm, State acess cause(s)                           | 23d. Date o Month  See contribut  No 3 { 24b. Wer prio dea 1 { 3 Octured  See fire do Number do Number do Number and manne and manne   | f defivery  bite to the Probab e autops: r to comp th? Yes 2 Specify)  or Rural F Print Md                            | ay Yeal cause of death ly 4 DUnki y findings availation of caus   |
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| ath.  The state this cardicate has been signed by the attending physicien end in the state of th | To Be Completed by Physician/Medical Ex                       | In mediate Cause in isease or condition resufting in death)  Sequentially list condition and is a cause. Enter Under Cause (Disease or that infittated events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death in the past 12 limited events resulting in the past 1 | Inditions, mindials whying injury stast to medical work with the pregnant months?  No ficant conditions with the predical conditions investigation of Could not be determined.   | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow contributing to deal  Hospital: 1 fnp 28a. Date of (Month, 12/15/05) 28e. Place of building resider hysician: To the bos                  | mhalation as a consequence of program of program as a consequence of program of program as a consequence of program of pr | uence of):  uence | DEctopic pregna Other (specify, underlying cause  ont 3 DOA of 28c. It A M treet, factory, offi  | 26. Pl Other: 4 Injury at Work? 1   Yes 2  | ace of Death   Nursing Hom   20   (A) No V:   21   (a) o and place, as death occurred  | 23e. Did to the saturation of the control of the co | obacco u Yes 2{ an psy prmed? 2 □ No one) dence (how injur hous Street an wn, State access(s) date and               | 23d. Date o Month  See contribut  No 3 { 24b. Wer prio dea 1 { 3 Octured  See fire do Number do Number do Number and manne and manne   | f defivery  Define autops: r to comp th? Yes 2!   | ay Year cause of death live 4 Munker and Death live 4 Munker y findings availation of cause of the work of the cause of the cause (s)   |
| Medical<br>kaminer   | edical Certification: To Be Completed by Physician/Medical Ex | In mediate Cause in isease or condition resufting in death)  Sequentially list condition and is a cause. Enter Under Cause (Disease or that initiated events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death) I limited events resulting in death in limited events resulting in lin | Inditions, mindials whying injury stast to medical work with the pregnant months?  No ficant conditions with the predical conditions investigation of Could not be determined.   | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birth 4 Pregnan 9 Unknow contributing to deal  Hospital: 1 fnp 28a. Date of (Month, 12/15/05) 28e. Place of building resider hysician: To the bos                  | mhalation as a consequence of program of program as a consequence of program of program as a consequence of program of pr | uence of):  uence | DEctopic pregna Other (specify, underlying cause ont 3 DOA of 28c. If A M treet, factory, offith occurred at the occurred at the occurred at the occurred of t | 26. Pl Other: 4   Injury at Work? 1   Yes 2  | ace of Death   Nursing Hom   20   (A) No V:   21   (a) o and place, as death occurred  | 23e. Did to the dat the time.  | obacco u Yes 2{ an psy primed? 2 □ No one) dence (how injur hous Street an wn, State iCess cause(s) date and         | 23d. Date o Month  Isse contribution  Anne,  In place, and   | f defivery District to the Probab e autops: th? Yes 2!  Specify)  Or Rural F Princ Md er as state due to the          | ay Year  cause of death  cause of death  dy 4 MUnkr  y findings ava  eletion of cause  No  Route Number  CE Willia  ed.  ne cause(s)  |
| ath.  The state this cardicate has been signed by the attending physicien end in the state of th | edical Certification: To Be Completed by Physician/Medical Ex | inmediate Cause in isease or condition resufting in death)  Sequentially list condition and in the cause. Enter Under Cause (Disease or that infittated events resulting in death) I I I I I I I I I I I I I I I I I I I   | inditions, mindials whying injury stast tregnant months? No ficant conditions of the | a. Smoke Ir Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outco 1 Live birtl 4 Pregnan 9 Unknow contributing to deal contributing to deal 28a. Date of (Month, 12/15/00) 28e. Place of building resider hysician: To the building resider | mhalation as a consequence of program as a consequence of  | uence of):  uence of of of of of of of of of of of of of  | DEctopic pregna Other (specify, underlying cause of 28c. In A M treet, factory, office the occurred at the occurred at the occurred at the occurred of 29c. Lice  | ancy  26. Pl Other: 4  Injury at  Work?  Injury at  Inj | ace of Death   Nursing Hom   20   \( \sqrt{N} \) \( \sqrt{N} \)   2 \( \sqrt{N} \)   2 \( \sqrt{N} \)   3 \( \sqrt{N} \)   4 \( \sqrt{N} \)   5 \( \sqrt{N} \)   6 \( \sqrt{N} \)   6 \( \sqrt{N} \)   7 \( \sqrt{N} \)   7 \( \sqrt{N} \)   8 \( \sqrt{N} \)   9 \( \sqrt{N} \)   9 \( \sqrt{N} \)   9 \( \sqrt{N} \)   10 \( N       | 23e. Did to the dat the time.  | obacco u Yes 2{ an psy ymmed? 2 No pne) dence (e how injur hous Street an wn, State ICESS cause(s) date and 29d. Dat | 23d. Date of Month  se contribution of the Month  24b. Were prior dead of the Month | f defivery  te to the  Probab  e autops: r to comp th? Yes 2  Specify)  or Rural F  Princ Mil  er as state due to the | ay Year  cause of death  dy 4 MUnkr  y findings availetion of cause  No  Route Number  CE Willia  ed.  ne cause(s)  |

|   |  |   | For<br>State<br>Registrar   | State of Marylar  | nd / Depa        |                                     |  | Mental Hyg                            | eg. No. UU5                             | 42415  |  |
|---|--|---|---|---|------------------|-------------------------------------|--|---------------------------------------|---|--|--|
|   | Physici  | an  | Decedent's Name (First, Middle, Last  TOUNT   |   |                  | CMTIMIT                             | _  | 2. Date of Deal                       | Day Year                                | 3. Time of Death                                   |  |
|   | /Medic   | al  | JOHN  | JASPE:  | K                | SMITH                               | Jr. or Location of Death                   | DECEMB                                | ER 5 2005  4c. County of Death          | 11:06 A <sup>M</sup>                               |  |
|   | Examin   | er  | 4a. Facility Name (If not institution, give PRINCE GEORGE S   |   |                  | CHEVERI                             |  | 1                                     | PRINCE GEO                              |  |  |
|   | Funeral  |   | 5. Social Security Number 6. S  |   | last birthday)   | If Under 1 Year                     | If Under 24 Hrs.                           | 8. Date of Birth                      |   | place (State or Foreign<br>ntry)                   |  |
|   | Director   |   | 226-54-5136 Usual Residence of Decedent   | <b>x</b> <sup>M 2□ F</sup> 62                             | Yrs.             | Months Days                         | Hours Min.                                 | MARCH 2                               | 21 1943 VIR                             | GINIA  |  |
|   | filed within 72 hours after death with the Maryland Hygiene. Hygiene thrat inter then "neturel; or Items 23e or 28e-f show ent, the Madical Exam as must be rediffed at ent. |   | 10a. State 10b. County  | 10c. Ci   | ty, Town or Lo   | cation                              |  |                                       |   | 10d. Inside City Limits                            |  |
|   | or death with the Marylar<br>Items 23e or 28a-f show<br>per must be notified at  | Director  | MD PRINCE G   | EORGE'S   | SUITLAN          |                                     |  | ··· ··· · · · · · · · · · · · · · · · |   | 1 Yes 2 No   |  |
|   | vith th  | Dire  | 10e. Street and Number  |   |                  | 10f. Zip Code                       |  | 1                                     | 0g. Citizen of What Cou                 | ntry?  |  |
|   | s 23e  |   | 3705 SILVER PARK  | DRIVE # 101  12. Was Decedent Ever in U                   | C 12 1           | 20746                               | Historia Origin? (C                        |                                       | J.S.A.                                  | can Indian   |  |
| _                                       | ter dea  | Funeral   | <ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>  | Armed Forces?   | .5.              | f Yes, specify Cut                  | Hispanic Origin? (S<br>pan, Mexican, Puert | o Rican, etc.)                        | Black, White,                           |  |  |
| 50                                      | urs at   | þ   | 3 Widowed 4 Divorced  | If Yes, Give Year or Dates:                               |                  | 1 ☐ Yes 2 🛣 No                      | Specify:                                   |                                       | Specify: U.                             | S.A.   |  |
| 9500-91212                              | ba filed within 72 hours afte<br>Ital Hygiene.<br>Id othar then "neturel", or l<br>event, The Madical Exami  | Completed   | 15. Decedent's Ec<br>(Specify only highest gra  | lucation  | 16a. Dece        | dent's Usual Occu                   | pation                                     | rking                                 | 16b. Kind of Business/In                | ndustry  |  |
| 7                                       | ithin 7  | nple  | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                  |                                     | during most of wor<br>ed)                  | nang .                                |   |  |  |
| 7                                       | ygier<br>ygier<br>har th   |   | 8th   |   | LABO             | RER                                 | T 40 November 4- November 4                | (C) - A AA: (-()                      | PRIVATE                                 |  |  |
| D<br>E                                  | d d d  | Be  | 17. Father's Name (First, Middle, Last)   |   |                  |                                     |  | ne (First, Middle, I                  |   |  |  |
| <u> </u>                                | should ba filed<br>id Mental Hygi<br>marked othar<br>matic event,  | 은   | JOHN JASPER SMITI  19a. Informant's Name/Relationship (   |   | 10b Mailie       | a Addross /Ctros                    | EVELYN                                     |                                       | LEN<br>, City or Town, State, Zij       | - Cadol  |  |
| Maryland                                | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Importent: If item 27 is marke<br>eny injury or other treumatic.<br>enges.                                   |   | SHIRLEY SMITH/WI  |   |                  | 7                                   |  |                                       |   | 3704   |  |
|   | Heal<br>Heal<br>tem 2  |   | 20a. Method of Disposition  | 20b. i  | Place of Dispo   | sition (Name of                     |  |                                       | 20c. Location - City or To              |  |  |
| Baltimore,                              | Pages<br>nent of<br>int: If it<br>iry or o   |   | 1 X Burial 2 ☐ Cremation 3 ☐  `4 ☐ Donation 5 ☐ Other (Specify  | Hemoval from State  | •                | natory`or other pla<br>CEMETERY     | , I  | 2/2005                                | LANDOVER, MA                            | DVI AMIN   |  |
| ======================================= | artme<br>orten<br>injur  |   | 21. Signature Funeral Service Licen   |   |                  |                                     |  |                                       | INS FUNERAL                             |  |  |
| ñ                                       | permi<br>Depa<br>Impo<br>eny is  |   | ) - JOFA  |   |                  |                                     |  |                                       | R, MARYLAND                             |  |  |
|   | Hiysician  |   | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition | olications that caused the deal one cause on each line.   |                  |                                     |  |                                       | est,                                    | Approximate<br>Interval Between<br>Onset and Death |  |
|   | /Medical<br>xaminer  |   | resulting in death)   | Due to (or as a consec                                    |                  | -01-2                               | 0,000                                      | HULLA                                 |   | 19-2017  |  |
|   | Examiner   |   | Sequentially list conditions, if any, leading to immediate  | b   |                  |                                     |  |                                       |   |  |  |
|   | ed<br>Isit   | Examiner  | if any, leading to immediate cause Exter Indenying Cause (Disease or injury   | Due to (or as a consec                                    | juence of):      |                                     |  |                                       | -                                       |  |  |
|   | be executed<br>sician and<br>burial-transit  | хап   | that initiated events resulting in death) Last  | c. Due to (or as a consec                                 | quence of):      |                                     |  |                                       |   |  |  |
| 9/                                      | te be executed<br>ysician and<br>ie burial-transit   | calE  |   | d   |                  |                                     |  |                                       |   |  |  |
| 89                                      |  |   |   | . u.  |                  |                                     |  |                                       |   |  |  |
| ŏ                                       | death certifica<br>e attending ph<br>of for use as th  | Physiclan/Med   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Feta  |                  | Totasia assansa                     |  |                                       | 23d. Date of delive                     | ery  |  |
| n                                       |  | sicla   | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4 Pregnant at time of o                                   |                  | Ectopic pregnand<br>Other (specify) | -y<br>                                     |                                       | Month                                   | Day Year   |  |
| J.                                      | at the<br>by the   | hys   | 9 Unknown   | 1/2   | 56               |                                     |  |                                       |   |  |  |
| ທົ                                      | The law requires that the de<br>ate has been signed by the a<br>page 2 should be detached f  | by  | Part II. Other significant conditions of  |   | sulting in the u | nderlying cause gi                  | iven in Part I.                            |                                       | pacco use contribute to t               |  |  |
| ord                                     | w require<br>been si<br>should I   | ted   | Mesuson   |   |                  | ·                                   | <del></del>                                | 1 4                                   | es 2 No 3 Prot                          | bably 4 □Unknown                                   |  |
| Record                                  | has b  | Completed   | Cardiones   | pinating  | Anu              | rest                                |  | 24a. Was a<br>autops                  | v prior to co                           | opsy findings available<br>empletion of cause of   |  |
| _                                       | : The  |   |   |   |                  |                                     |  | perform<br>1 ☐ Yes                    | med? death?                             | 2 <b>X</b> No                                      |  |
| Vital                                   | Physicien:<br>r this certifica<br>ral director, p  | Be  | 25. Was case referred to medical examiner?  | Hospital:   | 4                | 0:                                  |  | ath (Check only on                    |   |  |  |
| ō                                       | ding Physicien: The the the the the this certificate he funeral director, page   | - To  | 1 ☐ Yes 2 ☑ No  27. Manner of Death   | 1 ☐ Inpatient 2 ☐  28a. Date of Injury  (Month, Day Year) | ER/Outpatier     | it 3□ DOA                           | 4 □ Nursing H                              |                                       | ence 6 Other (Special                   | fy)  |  |
| on                                      | ding<br>th.<br>: Afte<br>fune  | tlor  | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation   |   | Injury           | 28c. Inju<br>Wo<br>M 1              | ork?<br>]Yes 2.∏No                         |                                       | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |  |  |
| Division of                             | I or Attending<br>after death.<br>Diractor: After<br>I in by the fune  | ifica   | 3 ☐ Suicide 6 ☐ Could not be determined   | 288. Place of Injuly - At I                               | ome, farm, str   | eet, factory, office                |  |                                       | reet and Number or Rura                 | al Route Number,                                   |  |
|   | al or Att<br>s after d<br>al Diract<br>ad in by  | Certification:  | 4 🗀 nomicide  |   |                  |                                     |  |                                       |   |  |  |
|   | To the Hospital or within 24 hours after In the Funerel Dir co pletely filled in   | 29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Moderner) |   |   |                  |                                     |  |                                       |   |  |  |
|   | within co  | Σ   | 29b. Signature and title of certifier   | 11.   | 0                | 29 Licen                            | ise number                                 | 2                                     | 9d. Date signed (Month,                 | Day, Year)   |  |
|   | 12   |   | Parllen   | levoren   | V                | 120                                 | )WS Z                                      |                                       | 12-8-6                                  | 05   |  |
|   | CADR   |   | 30. Name and address of person who  | completed cause of death (Ite                             | n 23a) (Type,    | Print)                              | 7 A  | 121                                   | TSUINE                                  | UA 2 070   |  |
|   | -yr  |   | PAUL IT, DE   | VOLE MI)  | 7 1150           | LUCEUS                              | Bully R                                    | a MYSTI                               | 30,00                                   | - CO181  |  |
|   | Sta<br>Registi   |   | 31, Date filed (Month, Day, Year)   | 32. Registrar's Sign                                      | ature            |                                     |  |                                       |   |  |  |

|  |  |                  | for State Registrar  | State of N   |  |   |                                | of H                  | ealth a                             |                      | •                                    |                          | 0.0                    | 5           | 424                                   | 16               |
|--|--|------------------|--|--|--|---|--------------------------------|-----------------------|-------------------------------------|----------------------|--------------------------------------|--------------------------|------------------------|-------------|---------------------------------------|------------------|
|  | Dhuais   |                  | Decedent's Name (First, Middle   | Last)  |  |   | -                              |                       |                                     |                      | 2. Date of De<br>Month               |                          |                        | Voor        | 3. Time o                             | of Death         |
|  | Physici<br>/Medi   |                  | BEULAH   | SPEN   |  |   |                                |                       |                                     |                      | NOV                                  | 30                       | 20                     | 905         | 7:04                                  | ¼ a <sup>M</sup> |
|  | Examir   | er               | 4a. Facility Name (If not institution,   |  |  |   |                                |                       | Location of                         | f Death              |                                      | 4c.                      | County of              | Death       |                                       |                  |
| 1  |  |                  | Washington Adve  |  |  | last birthday)                              |                                |                       | Park<br>If Under 2                  | 24 Hrs.              | 8 Date of Bi                         | dh                       | Monte                  | ome         | ry                                    | as Famiga        |
| -10° \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | Funeral<br>Director  | 81               | 579-24-7380 Usual Residence of Decedent  | 1 M 2 12kF   | 84   | Yrs.  |                                | Days                  | Hours                               | Min.                 | 8. Date of Bi<br>(Month, D.<br>Sept. | ay, Year)<br>25 <b>,</b> | 1921                   | Nor         | th Car                                | colina           |
|  | filed within 72 hours after death with the Maryland<br>Hyglene.<br>yther than "netural", or items 23s or 28s-f show<br>ent, the Medical Executer must be notified at   |                  | 10a. State 10b. County   |  | 10c. C   | ty, Town or Lo                              | ocation                        |                       |                                     |                      |                                      |                          |                        |             | Od. Inside C                          |                  |
|  | B Mar  | Funeral Director | DC   |  | W  | ashing                                      | ton                            |                       |                                     |                      | _                                    |                          |                        |             | 1 X Yes                               | 2 □ No           |
|  | or 28  | Dire             | 10e. Street and Number   |  |  |   | 10f. Zip (                     | Code                  |                                     |                      |                                      | 10g. Cit                 | izen of Wh             | at Cour     | ntry?                                 |                  |
|  | s 23s  | rai              | 4319 7th St. N   |  |  |   |                                | 2001                  |                                     |                      |                                      |                          | SA                     |             |                                       |                  |
|  | item<br>item   | nue              | 11. Marital Status  1 XNever Married 2 Marrie  | 12. Was Deceder Armed Forces ad 1 □ Yes 2 □  | s?   | J.S. 13.                                    | Was Decede<br>If Yes, speci    | ent of Hi<br>fy Cuba  | sp <i>a</i> nic Orig<br>n, Mexican, | in? (Spe<br>, Puerto | ecify Yes or No<br>Rican, etc.)      | 0-                       |                        | White,      | an Indian,<br>etc.                    |                  |
| 920  | urs af   | þ                | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates  | _  |   | 1 ☐ Yes 2                      | No No                 | Specify:                            |                      |                                      |                          | Specify:               | Bla         | o c le                                |                  |
| Ö  | 72 hor   | Completed        | 15. Decedent   |  |  |   | dent's Usual                   |                       |                                     | -6                   |                                      | 16b. K                   | ind of Bus             |             |                                       |                  |
| 2  | ithin .  | npie             | (Specify only highest<br>Elementary/Secondary (0-12)   | College (1-4o  | r 5+)  | life.                                       | kind of work<br>DO NOT use     | e retired,            | uning most                          | OI WOIKI             | ing                                  |                          |                        |             |                                       |                  |
| Maryland 21215-0036                        | led w<br>tygier<br>her th  | ပိ               | 47 Fabras Name (Fine Middle )  | 3 yrs.   |  | Clerk                                       |                                | Ţ                     | 10.11.1                             |                      | (5)                                  |                          |                        |             | ninstr                                | ation            |
| and  | t be find H  | Be               | 17. Father's Name (First, Middle, L  |  |  |   |                                |                       |                                     |                      | e (First, Middle                     | , Maiden                 | Sumame,                | )           |                                       |                  |
| Ž  | thould<br>d Me<br>mark<br>matic  | မ                | Abram Spencer  19a. Informant's Name/Relationsh  |  |  | 19h Maili                                   | na Address                     | (Street a             | John                                |                      |                                      | or City o                | s Tours Co             | ato Zie     | Code                                  |                  |
| Z  | od 2 s<br>lith an<br>27 is<br>r trau   |                  | Abram Spencer,   |  | r  | 5440  | 27th                           | St.                   | N.W.                                | 1 E                  | al Route Numb                        | er, ony o                | 1 10WII, 31            | агө, гір    | (000)                                 |                  |
|  | F Hea  |                  | 20a. Method of Disposition   | JI . / DIOCHE.   | 20b.   | □ Wash.<br>Place of Dispo<br>cemetery, crea | ington                         | e of                  |                                     | 12                   | Date                                 | 20c. Lo                  | cation - C             | ity or To   | wn, State                             |                  |
| Ë  | Page<br>ent o<br>nt: If<br>ry or   |                  | 1 ☑ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (Sp   |  | 8  | • Lince                                     |                                | Ter place             |                                     | 2-7-                 | 2005                                 | Bra                      | entwo                  | od          | Md                                    |                  |
| altimore,                                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Macital Examiner must be notified at ance. |                  | 21. Signature of Funeral Service L   |  | -1   | 25  | 2 Name and                     | Addres                | s of Eacility                       | ,                    |                                      |                          |                        | ou,         | ria.                                  |                  |
| m  | Depa<br>Impo<br>eny is   |                  | A, P, ///  | arshal   |  | 1   | Marsha<br>4217 9               | th S                  | s Fune<br>St. N                     | eral<br>.W.          | Home,<br>Washi                       | Inc                      | DC                     | 200         | )11                                   |                  |
| Ti kr                                      | Physician<br>/Medical  |                  | 23a. Part. Enter the disease, or or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)   | complications that causinly one cause on each  a   | line.  | th. Do not ent                              | ter the mode                   | of dying              | , such as c                         | cardiac c            | or respiratory a                     |                          |                        |             | Approxima<br>Interval Be<br>Onset and | tween            |
| 68760,                                     | icate be executed physician and physician and s the burial-transit   | edicai Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. — Due to (or a c. — Due to (or a d  | is a consec  | quence of):                                 | 70N                            | PN                    | EVM                                 | MON                  | 1/\                                  |                          |                        |             |                                       |                  |
| P.O. Box                                   | the death certificate by<br>the attending physic<br>ached for use as the b   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1   |  |  |   |                                |                       |                                     |                      |                                      | 23d. Date (<br>Month     |                        | -           | Year                                  |                  |
|  | The law requires that the der<br>ate has been signed by the a<br>bage 2 should be detached for   |                  | Part II. Other significant condition   |  | but not res  | sulting in the u                            | nderlying ca                   | use give              | n in Part I.                        |                      |                                      |                          | 1                      |             | e cause of ably 4                     |                  |
| ဝ္ပ  | aw requir<br>s been si<br>s should   | ojete            | A 20TEMIA,   | MEDAB  | OUC  | AUG   | 1605/1                         | ٢,                    |                                     |                      | 24a. Was                             |                          | 24b. We                | re auto     | psy findings                          | available        |
| ia<br>E                                    | sician: The law<br>certificate has b<br>irector, page 2 s  | Completed by     | HYPERCALI 25. Was case referred to medical   | OBSTRO   | autopsy performed? prior to completion of cause of death? 1 Yes 2 1 No |   |                                |                       |                                     |                      | cause of                             |                          |                        |             |                                       |                  |
| >  | ysicis<br>s cert<br>direct   | To Be            | examiner? 1 Yes 2 70   | Hospital: Inpat  | tient 2  | ER/Outpatier                                | at 3 DOA                       | Othe                  | r                                   |                      |                                      |                          | 3 Other                | (Specifi    | d)                                    |                  |
| Division of Vital Records,                 | Attending Physician: Ir death. ector: After this certifice by the funeral director, p  | ation: T         | 27. Manner of Death  1 Natural 5 Pending   | 7. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how in |  |   |                                |                       |                                     |                      |                                      |                          |                        |             | 7                                     |                  |
| DIVIS                                      | 7 = 2  | Certification:   | 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Num. City or Town, State) |  |  |   |                                |                       |                                     |                      |                                      | d Number                 | or Rura                | l Route Nun | nber,                                 |                  |
|  | To the Hospital of within 24 hours at To the Funeral D completely filled in  | Medical (        | 29a. Certifier (Check only one) Certifying 2 Medical E   | Physician: To the bes<br>xaminer: On the basis<br>and manners  | of examina   | owledge, death<br>ation and/or in           | h occurred a<br>vestigation, i | t the tim<br>in my op | e, date and<br>inion, death         | place, a             | and due to the ed at the time,       | cause(s)<br>date and     | and mann<br>place, and | er as st    | ated.<br>the cause(s                  | s)               |
|  | To the complet   | W                | 29b. Signature and title of certifier  | unsur  | dan  |   | 5                              | )53                   | 136 7                               | -                    |                                      | Not                      |                        |             | 30 W,                                 | 2005             |
| -  | 4  |                  | 30. Name and address of person w   | no completed cause of  | death (Iter<br>, Sim   | n 23a) (Туре,<br>G: 202                     | Print) St                      | MA                    | MSUR                                | VD/7                 | R. RAJ                               | 74N<br>208               | 78,                    |             |                                       |                  |
|  | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  DEC 1 3 2   | Regis 2  | trar's Signa   | ature                                       | D                              | .,,                   |                                     | -11                  |                                      |                          |                        |             |                                       |                  |

|  |   |                | 1- For Amend Item 8 per FH, C831, of Persistent of Health and Mental Hy Certificate of Death   | rgiene 005  | 42417  |
|--|---|----------------|--|---|--|
|  | Physici<br>/Medic   |                | JOHN FINEST SHELLOH WAXAND   | ber Day 2, 200                                    | 3. Time of Death<br>5 12:25A M                                     |
| ************************************** | Examir  | er             | Doctor's Community Hospital Lanham   | 4c. County of Dea<br>Prince                       | Coorgo! c  |
|  | Funeral<br>Director   |                | 5. Social Security Number  5. Social Security Number  5. Social Security Number  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Yrs.  1 If Under 1 Year  Hours  Min.  June 2  June 2   | ay, Year) 8, 1926 Ne                              | thplace (State or Foreign buntry)  W Mexico                        |
|  | Maryland<br>f show  | or             | 10a. State 10b. County 10c. City, Town or Location   |   | 10d. Inside City Limits 1 XYes 2 No                                |
|  | with the<br>3e or 28a-  | i Directo      | Maryland Prince George's New Carrollton  10e. Street and Number 10f. Zip Code  8306 Longfellow Street 20784  | 10g. Citizen of What Co                           | ountry?  |
| 9                                      | should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or itama 23e or 28e-f show marked other than "natural", or itama 23e or 28e-f show maric avent, the Medical Examinar must be notified at | / Funerai      | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married  13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  |   |  |
| _                                      | n 72 hours<br>"natural",<br>edical Exe  | ieted by       | 3  | 16b. Kind of Business                             | ite<br>Andustry  |
| d 212                                  | ould be filed within<br>I Mental Hygiene.<br>Parked other than "I<br>hatic avent, the Mer   | e Completed    | Elementary/Secondary (0-12)  College (1-4or 5+)  4+  Metallurgist  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle)  | Governm   | ent  |
| ylan                                   | should be<br>nd Mental<br>marked c  | To Be          | Guy E. Shelton Ellene Earnh  |   |  |
| _                                      | Ith at  |                | 19a. Informant's Name/Relationship (Type, Print)  Lois Shelton (Wife)  19b. Mailing Address (Street and Number or Rural Route Numb  8306 Longfellow STreet, New  |   |  |
| ltimore,                               | 0° = 5  |                | 20a. Method of Disposition  1  Burial  | 20c. Location - City or Beltsvill                 |  |
| Balt                                   | permit. Pag<br>Department<br>Important:<br>any injury o   |                | 21. Signature Funeral Service Licensee 22. Name and Address of Facility Rendon/Ha 9013 Annapolis Road, Lan   |   |  |
|  | Physician<br>/Medical   | J              | 23a. Panl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and nock, or heart failure List only one cause on each line.  Jumediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):   | rrest,  | Approximate<br>Interval Between<br>Onset and Death<br>111011 Class |
| 27                                     | Examiner  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury by instructions of the cause of the caus |   |  |
| 68760,                                 | ficate be executed<br>physicien and<br>is the burial-transit  | edical Exa     | resulting in death) Last Due to (or as a consequence of):  |   |  |
| Box.                                   | death certi<br>e attending<br>id for use a  | Physician/Med  |  | 23d. Date of del<br>Month                         | ivery<br>Day Year  |
|  | The law requires that the de<br>sie has been signed by the a<br>page 2 should be detached to  | ρ              | Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.   | tobacco use contribute to<br>Yes 2□No 3□Pr        |  |
| al Reco                                |   | Completed      | 24a. Was auto perfo  | psy prior to death?                               | utopsy findings available<br>completion of cause of<br>2 No        |
| of VII                                 | al d  | n: To Be       | examiner?  1   Yes   |   | cify)  |
| -                                      |   | Sertification: | 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (City or To  | Street and Number or Ruwn, State)                 | ıral Route Number,   |
|  | To the Hospital of within 24 hours af To the Funeral D completely filled in   | edical C       | 29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.   | cause(s) and manner as<br>date and place, and due | stated.<br>to the cause(s)   |
|  | Veith Com   | Σ              | 29b. Signature and title of certifier  29c. License number  DOV 62116  | 29d. Date signed (Mont.                           |  |
| 2                                      | (10)  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Meklit Worknem, M.D. 722-A Hanover Parkway, Greenbelt, MD 2  | 0770  |  |
|  | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) 32 Registrar's Signature   |   |  |

|          |  |                | For<br>State<br>Registrar  |  | State of N                          | Marylan            |                        | artment of I<br>rtificate of                                |                             | and Me       |                         | jiene       | 005  | 42418                               |
|----------|--|----------------|--|--|-------------------------------------|--------------------|------------------------|---|-----------------------------|--------------|-------------------------|-------------|--|-------------------------------------|
|          | Physicia   | an             | Decedent's Name (Fire  |  |                                     |                    |                        |   |                             | 2            | 2. Date of Dea<br>Month | th<br>Day   | Year   | 3. Time of Death                    |
|          | /Medic   |                |  |  | . Smith                             |                    |                        |   |                             |              | Decembe                 | r 2,        | 2005   | 2:15P M                             |
|          | Examin   | er             | 4a. Facility Name (If not a Southern M   |  |                                     |                    |                        | 4b. City, Town, o   |                             | of Death     |                         |             | ounty of Death                                       |                                     |
|          | Funeral  |                | 5. Social Security Number  |  | -                                   |                    | last birthday)         | If Under 1 Year   |                             | 24 Hrs.   8  | B. Date of Birth        | 1           |  | place (State or Foreign             |
|          | Funeral<br>Director  |                | 579-07-037   | 6 1                                    | □M 2½0F                             | 85                 | Yrs.                   | Months Days   | Hours                       |              |                         |             | 20Balfi  | more, Md.                           |
|          | p ,  |                | Usual Residence of Dec   |  |                                     | 10.00              |                        |   |                             |              |                         |             |  |                                     |
|          | anyla<br>shov  | ž              |  | . County                               |                                     |                    | y, Town or Lo          |   |                             |              |                         |             |  | 10d. Inside City Limits 1 AYes 2 No |
|          | the N  | Director       | 10e. Street and Number   | rince (                                | eorges                              | 16                 | emple 1                | 10f. Zip Code   |                             |              |                         | IOo Citize  | en of What Cou                                       |                                     |
|          | deeth with the Maryland<br>ms 23a or 28a-f show<br>rinust be notified at   |                |  | Ave.                                   |                                     |                    |                        |   | 748                         |              |                         |             | ited St  | •                                   |
|          | deeth<br>ms 2  | Funeral        | 11. Marital Status   |  | 12. Was Deceder<br>Armed Force      | t Ever in U.       | S. 13.                 | Was Decedent of   | Hispanic Orig               | gin? (Speci  | ify Yes or No-          |             | . Race - Ameri                                       | can Indian,                         |
| 0        | after<br>or its  |                | 1 Never Married  |  | 1 ☐ Yes 28                          |                    |                        | f Yes, specify Cub<br>1 ☐ Yes 250KNo                        |                             | , Риепо ні   | ican, etc.)             |             | Black, White,  | . etc.<br>.ack                      |
| 3        | 72 hours after<br>natural', or ite   | d by           | 3€ Widowed 4 □   |  | Year or Dates                       | s:                 |                        |   |                             |              |                         |             |  |                                     |
| 2        | in 72  | olete          | (Specify or  | 7                                      | de completed)                       |                    | (Give                  | dent's Usual Occu<br>kind of work done<br>DO NOT use retire | pation<br>during most<br>d) | t of working | ,                       | 16b. Kind   | of Business/In                                       | ndustry                             |
| 7        | d within<br>piene.<br>r than "   | Completed      | Elementary/Secondary   | y (0-12)                               | Cotlege (1-4o                       | r 5+)              | 1                      | tor of Se   |                             |              |                         | Gove        | ernment  |                                     |
| 2        | be filed<br>Ital Hygi<br>of other<br>event, I  | BeC            | 17. Father's Name (First,  |  |                                     |                    |                        |   |                             |              | First, Middle,          | Maiden S    | umame)   |                                     |
| 2        | should b<br>nd Ment<br>marked<br>umatic e  | To             | Solomon Ma   | arshall                                | •                                   |                    |                        |   | Vir                         | gie R        | logers                  |             |  |                                     |
|          | 12 sh<br>and<br>ris m  | W.             | 19a. Informant's Name/F  |  |                                     |                    |                        | ng Address (Street  |                             |              |                         |             |  | Code)                               |
| ກ໌       | 1 end<br>Heelth<br>em 27<br>ther tr  |                | Alfred S   |  | on                                  | 20b. P             | 4006                   | 22nd Ave  | nue; T                      | emple<br>Da  |                         |             | <ul> <li>2074</li> <li>ation - City or To</li> </ul> |                                     |
| 5        | Pages<br>nent of<br>int: If its<br>iry or o  |                | 1 ☑ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐  | emation 3 🗆                            |                                     | 10                 |                        | sition (Name of<br>matory or other pla                      | 1                           |              |                         |             |  |                                     |
| altimo   | 글 된 본글 .   |                | 21. Signature of Funeral   |  |                                     |                    |                        | Memorial<br>. Name and Addre                                |                             |              | 2005<br>se Fune         |             |  | D.                                  |
| Ď        | Depermine Deperm |                | Point (  | Than                                   | you MO                              | 1085               | _                      |   |                             | 553<br>For   | 8 Marl                  | borg        | Dike<br>20   | 747                                 |
|          |  |                | 23a. Part1: Enter the dis<br>shock, or heart fail  | sease, or comp                         | olications that caus                | ed the death       | h. Do not ent          | er the mode of dy   | ng, such as                 | cardiac or   | respiratory arr         | est,        |  | Approximate<br>Interval Between     |
|          | Physician  |                | Immediate Cause (Final disease or condition  |  | Acu                                 | 1                  | cardial                | Infancti  | 4                           |              |                         |             |  | Onset and Death                     |
|          | /Medical<br>Examiner   |                | resulting in death)  |  | d                                   | as a consequ       | uence of):             |   | `                           |              |                         |             |  |                                     |
|          | Zammer   | -              | Sequentially list condition  | ons,                                   | b. Mherosi                          | lew hi             |                        | say aloten  | Justan                      | 1            |                         |             |  |                                     |
|          | ned<br>Insit   | Examiner       | Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury) | ************************************** | D00 t0 (01 t                        | is a consequ       | Berice Oi).            | 1   |                             |              |                         |             |  |                                     |
| 5        | execu<br>in and<br>ial-tra   | Exal           | that initiated events<br>resulting in death) Last  | - 1                                    | Due to (or a                        | as a consequ       | uence of):             |   |                             |              |                         |             |  |                                     |
| 00/00    | certificate be executed<br>nding physician and<br>use as the burial-transit  | edicai         |  | •                                      | d                                   |                    |                        |   |                             |              |                         |             |  |                                     |
| _        | artifica<br>ing ph<br>e as th  | Med            | IF FEMALE:   |  |                                     |                    |                        |   |                             |              |                         |             |  |                                     |
| X<br>D   | w requires that the death certif<br>been signed by the attanding<br>should be deteched for use a   | Physician/M    | 23b. Was decedent preg   | grianii                                | 23c. if yes, outcom<br>1☐Live birth | 2 Fetal            | Ideath 3               | Ectopic pregnanc  | у                           |              |                         | 23          | d. Date of delive<br>Month                           | ery<br>Day Year                     |
| 5        | the de   | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  |  | 4□Pregnant<br>9□Unknown             |                    | eath 5L                | Other (specify) _   | <del>.</del>                |              |                         |             |  | ou, rous                            |
| ŗ.       | requires that the  | y Ph           | Part II. Other significant   | t conditions o                         | ontributing to death                | but not resi       | ulting in the u        | nderlying cause gr  | ven in Part I.              |              | 23e. Did to             | bacco use   | contribute to t                                      | he cause of death?                  |
| ecoras   | quires<br>n sign   | Completed by   | Recurrent  | nationa                                | it lest ple                         | wed t              | This .                 |   |                             |              | 1 1 Y                   | es 2.⊡∕     | No 3□Prot  | bably 4 Unknown                     |
| 000      | law rei<br>es bee<br>2 shoi  | piet           |  | Ũ                                      | ٧                                   |                    |                        |   |                             |              | 24a. Was a              |             | 24b. Were auto                                       | opsy findings avaitable             |
|          | The<br>ste h<br>page   | mo:            |  | हेर्न्य                                |                                     |                    |                        |   |                             |              | autops<br>perform       | med?        | prior to co<br>death?<br>1 \( \sum \text{Yes}        | impletion of cause of               |
| VIGE     | clen:<br>Brtifico  | Bec            | 25. Was case referred to examiner?   | medical                                | 7.                                  |                    |                        |   | 26. Place                   | of Death     | Check only or           |             |  | 20.00                               |
| 5        | hysic<br>this co   | ပ္             | 1 ☑Yes 2 ☐ No  |  | Hospital: 1 ☑ Inpa                  |                    | ER/Outpatien           | I 3 DOA   |                             |              |                         |             | □Other (Specif                                       | fy)                                 |
|          | ting f   | ion            |  | ☐ Pending                              |                                     | ojury<br>Day Year) | 28b. Time of<br>Injury | Wo  | ryat<br>rk?<br>]Yes 2.⊟1    |              | ld. Describe h          | ow injury ( | occurred   |                                     |
| DIVISION | death<br>death<br>ctor:<br>y the   | fical          |  | investigation Could not be determined  |                                     | niury - At ho      | ome, farm, str         | eet, factory, office  | 105 2 🗆 1                   |              | If Location (S          | reet and i  | Number or Rus  | al Route Number,                    |
| 2        | al or /<br>s efter<br>if Dire  | Certification; | 4  Homicide  | determined                             | building,                           | etc. (Specify      | y) -,,                 | 000, 12000, 7, 011100                                       |                             |              | City or Town            | n, State)   |  | ar riodio riomber,                  |
|          | To the Hospitel or Attending Physicien: within 24 hours elter death.  To the Funeral Director: After this certifical completely filled in by the funeral director.   | caic           | 29a. Certifier (Check only 2   | Certifying Ph                          | ysician: To the bei                 | st of my kno       | wladge death           | occurred at the ti  | me date an                  | d placa, an  | d due to the o          | ausu(s) a   | nd manner as s                                       | Aet Jd.                             |
|          | the H<br>nin 24<br>the Fi  | fedical        |  | <i>A</i> ,                             | niner: On the basis<br>and manner   | stated.            | tion and/or in         |   |                             | th occurred  | at the time, d          | ate and p   | lace, and due to                                     | o the cause(s)                      |
|          | To To  | Σ              | 29b. Signature and title   | ot certifier                           | -lum                                | 10.                |                        | 29c. Licen:   |                             |              |                         |             | signed (Month,                                       |                                     |
|          |  |                |  | Λ"                                     |                                     | m,J                | -                      | 1   | 05512                       | -0           |                         | De:         | 3~4 20E  | 15                                  |
| )        | (4)  |                | 30. Name and address of  | ver mb                                 |                                     |                    |                        | Print)  | , (11)                      | Want.        | who h                   | c 2         | 0032   |                                     |
|          | Sta  | te             | 31. Date filed (Month, Da  |  |                                     | strar's Signa      |                        | 41 441  | 1 212                       | 0.0300       | inglost O               |             | - 002  |                                     |
|          | Registr  |                | DEC 1  | 3 2005                                 | Marie .                             | , K                | Line                   | 60  |                             |              |                         |             |  |                                     |

| Direction   Dire   | 12119  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| Take the property of the prope | 3. Time of Death                                   |  |  |  |  |  |  |  |  |
| St. Thomas More Nursing Rome  Social Security 2006  Social Securit |  |  |  |  |  |  |  |  |  |
| Second Security 1998   12  |  |  |  |  |  |  |  |  |  |
| Director   100     | irthplace (State or Foreign                        |  |  |  |  |  |  |  |  |
| Do State Do Do Do Do Do Do Do Do Do Do Do Do Do  | ıth Carolina                                       |  |  |  |  |  |  |  |  |
| Specify only highest grade completed)   Give kend of use down during most of working file. On NOT use retired   Janitor   Ja   | 10d. Inside City Limits                            |  |  |  |  |  |  |  |  |
| Specify only highest grade completed)   Give kend of use down during most of working file. On NOT use retired   Janitor   Ja   | 1 X Yes 2 ☐ No                                     |  |  |  |  |  |  |  |  |
| Specify only highest grade completed)   Give kend of use down during most of working file. On NOT use retired   Janitor   Ja   | Country?   |  |  |  |  |  |  |  |  |
| Specify only highest grade completed)   Give kend of use down during most of working file. On NOT use retired   Janitor   Ja   |  |  |  |  |  |  |  |  |  |
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| Specify only highest grade completed)   Give kend of use down during most of working file. On NOT use retired   Janitor   Ja   | 31ack  |  |  |  |  |  |  |  |  |
| To go to go  | s/Industry   |  |  |  |  |  |  |  |  |
| To go to go  | Cabool c   |  |  |  |  |  |  |  |  |
| Herbert J. Smith    19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 21   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 21   19a. Informant's Name/Relationship (Type, Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 22   19b. Place of Disposition (Name of cemetery, crematory or other place)   20a. Leathord of Disposition   18b. Burial   2   2   Cremation   3   Removal from State   20b. Place of Disposition (Name of cemetery, crematory or other place)   22c. Laurem and Address of Facility Ohnson and Jenkins Fu   716 Kennedy St. NW Washington, DC 200   22a. Part. Enter the cliesaes, or complicitions that causes the seath Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallium: List only one cause of neach interest in the past 12 months?   1   2   2   2   2   2   2   2   2   2   | Schools  |  |  |  |  |  |  |  |  |
| 19a. Informants NamarRelationship (Type, Print) Teresa Smith / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2it 194 of 2it 194  |  |  |  |  |  |  |  |  |  |
| 20a. Method of Disposition   20c. Location - City or T   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   185 Burial 2   Cremation   3   Removal from State   20c. Method of Disposition   20c. Method of Disposition   20c. Method of Disposition   20c. Method of Disposition   20c. Method of Disposition   20c. Method of Disposition   20c. Method of Disposition   20c. | Zip Code)  |  |  |  |  |  |  |  |  |
| 1  | or Town State                                      |  |  |  |  |  |  |  |  |
| Physician / Medical Examiner  23a. Pant: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sequentially list conditions, resulting in death)  25a. Pant: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sequentially list conditions, resulting in death)  25a. Pant: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one texts on each line. Immediate Cause (Final Shock, or heart failure. List only one texts on each line. Immediate Cause (Final Shock, or heart failure. List only one texts on each line. Immediate Cause (Final Shock) or heart failure. List only one texts on each line. Immediate Cause (Final Shock) or heart failure. List only one texts on each line. Immediate Cause (Final Shock) or heart |  |  |  |  |  |  |  |  |  |
| Physician / Medical Examiner  23a. Pant: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sequentially list conditions, resulting in death)  25a. Pant: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Sequentially list conditions, resulting in death)  25a. Pant: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one cause on each line. Immediate Cause (Final Shock, or heart failure. List only one texts on each line. Immediate Cause (Final Shock, or heart failure. List only one texts on each line. Immediate Cause (Final Shock, or heart failure. List only one texts on each line. Immediate Cause (Final Shock) or heart failure. List only one texts on each line. Immediate Cause (Final Shock) or heart failure. List only one texts on each line. Immediate Cause (Final Shock) or heart |  |  |  |  |  |  |  |  |  |
| Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Physician // Medical Examiner  Sequentially list conditions, and in the past 12 months of a consequence of):  OSTEOMYELITIS, HIP JOINTS, BILAT  Due to (or as a consequence of):  O. The past 12 months of a consequence of):  Due to (or as a consequence of):  Due  | 0011   |  |  |  |  |  |  |  |  |
| disease or condition resulting in death)    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)   Due to (or as a consequence of):   OSTEOMYELITIS, HIP JOINTS, BILAT  | Approximate<br>Interval Between<br>Onset and Death |  |  |  |  |  |  |  |  |
| Due to (or as a consequence of):  OSTEOMYELITIS, HIP JOINTS, BILAT  Due to (or as a consequence of):  OSTEOMYELITIS, HIP JOINTS, BILAT  Due to (or as a consequence of):  OSTEOMYELITIS, HIP JOINTS, BILAT  Due to (or as a consequence of):  Due to | Criset and Death                                   |  |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown 9  |  |  |  |  |  |  |  |  |  |
| That initiated events resulting in death) Last    Due to (or as a consequence of):   |  |  |  |  |  |  |  |  |  |
| Second   S   |  |  |  |  |  |  |  |  |  |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   Month   2   Fetal death   3   Ectopic pregnancy   23d. Date of delive   23d. Date of d   |  |  |  |  |  |  |  |  |  |
| The state of the past 12 months?  In the past 12 months? In the past |  |  |  |  |  |  |  |  |  |
| The state of the s | •  |  |  |  |  |  |  |  |  |
| HYPERTENSIVE CARDIOVASCULAR DISEASE    1   | Day Year   |  |  |  |  |  |  |  |  |
| CEREBROVASCULAR ACCIDENT  SEIZURE DISORDER  24a. Was an autopsy performed? 1 yes 24b. Were autoprior to ordeath? 1 yes 25 No. 1 yes 25  | to the cause of death?                             |  |  |  |  |  |  |  |  |
| CEREBROVASCULAR ACCIDENT  SEIZURE DISORDER  24a. Was an autopsy performed? 1 yes 24b. Were autoprior to ordeath? 1 yes 25 No. 1 yes 25  | robably 4 Unknown                                  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?  1   Yes   2   Xes   No   2   ER/Outpatient   3   DOA   Cther: 4   Nursing Home   5   Residence   6   Other (Special Property of the Control of | autopsy findings available ocompletion of cause of |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?  1   Yes   2   Xes   No   2   ER/Outpatient   3   DOA   Cther: 4   Nursing Home   5   Residence   6   Other (Special Property of the Control of | s 2 No   |  |  |  |  |  |  |  |  |
| 9 0 1 1 Yes 2 1 ANO 1 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 4 Nursing Home 5 □ Residence 6 □ Other (Speci  |  |  |  |  |  |  |  |  |  |
| C S S S S S S S S S S S S S S S S S S S  | ecify)   |  |  |  |  |  |  |  |  |
| 2   Accident investigation   M   1   Yes 2   No  |  |  |  |  |  |  |  |  |  |
| 28t. Location (Street and Number or Rur  | Rural Route Number,                                |  |  |  |  |  |  |  |  |
| To the policy of |  |  |  |  |  |  |  |  |  |
| 29a. Certifier  29b. Signature and title of certifier  29b. Date signed (Month.)   | is stated.<br>re to the cause(s)                   |  |  |  |  |  |  |  |  |
| and manner stated.  29b. Signature and title of certifier  29d. Date signed (Month,  | nth. Day, Year)                                    |  |  |  |  |  |  |  |  |
| Doubles, My Doubling December 6,   | , 2005   |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Esmerando Juanitez, MD 1150 Varnum Street NE Washington, DC 20017  |  |  |  |  |  |  |  |  |  |
| State Registrar  31. Date filed (Month, Day, Year) DEC 1 4 2005  Registrar's Signature   |  |  |  |  |  |  |  |  |  |

|            |   |                   | 1- For State Registrar Amend Item  | State of Marylar  | nd / Depa        | artment of H   | Health and  | Mental Hy                            |                      | 9005   | 4242   | 0         |  |
|------------|---|-------------------|--|---|------------------|--|---|--------------------------------------|----------------------|--|--|-----------|--|
|            | Physici<br>/Medic   |                   | 1. Decedent's Name (First, Middle, Last)   | JOEL MILES T  |                  | 107100 <u>J</u>  | •   | 2. Date of De                        |                      |  | 3. Time of Deal 2:49 P                             | ith<br>M  |  |
|            | Examir  |                   | 4a. Fecility Name (If not institution, give s NATIONAL NAVAL MEDI 5. Social Security Number 6. Sex   | CAL CENTER  | last hirthday    |  | THESDA  If Under 24 Hrs                               |                                      |                      | MONT GON   | MERY   |           |  |
|            | Funeral<br>Director   |                   | Usuel Residence of Decedent  | M 2□F 73  | Yrs.             | Months Days  | Hours Min.  | March 1                              | y, Year,<br>4,1      | 932 Nort   | plece (Stete or For<br>htry)<br>N Caroliv          | ian<br>10 |  |
|            | h the Marylani<br>r 28a-f show<br>r notified at   | Director          | Vinginia Loudoun  10e. Street and Number   |   | onian S          | Springs<br>10t. Zip Code                                     |   |                                      | 10g. Ci              | itizen of What Cou                                 | 10d. Inside City Lin 1 ☐ Yes 2 ☐ ntry?             |           |  |
| 136        | 72 hours after death with the Maryland<br>Insturet, or items 23s or 28s-f show<br>disal Examinar must be notified at                                | by Funeral D      | 39924 Catoctin Ridge 11. Marital Status 1 Never Married 2 🔯 Married 3 Widowed 4 Divorced   | e Street  2. Was Decedent Ever in U Armed Forces?  1 XYes 2 □ No If Yes, Give 1951          | .s. 13. Y        | 20129<br>Was Decedent of H<br>f Yes, specify Cub             | dispanic Origin? (S<br>an, Mexican, Puerl<br>Specify: | Specify Yes or No<br>to Rican, etc.) | u.s                  | • A  14. Race - Amen Black, White,  Specify: White | etc.   |           |  |
| 9500-61212 | d within 72 hou<br>giene.<br>or than "nature<br>. I'm Medical E.  | Completed         | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)<br>12  | eation  | (Give            | tent's Usual Occup<br>kind of work done<br>DO NOT use retire | during most of word)                                  | rking                                |                      | (ind of Business/In                                |  | <br>orc   |  |
| yland      | should be file<br>nd Mental Hyg<br>marked othe<br>matic event,  | To Be C           | 17. Father's Name (First, Middle, Last)  Bee Ashley Thomas  19a. Informant's Name/Relationship (Ty)  | pe. Printl  | 19b. Mailin      | o Address (Street  | 18. Mother's Nar<br>Elva Gra<br>and Number or Ru      |                                      | ı                    | <u> </u>   | Codel  |           |  |
| оге, маг   | es 1 and 2 should<br>of Health and Mer<br>f item 27 is marke<br>ir other traumatic  |                   | Mary M. Thomas - Wa<br>20a. Method of Disposition<br>1 ☐ Burial 2 ☐ Cremation 3 ☐ Re   | Ge 20b. F   | P.O. 1           |  | ieonian S   |                                      | VA :                 |  |  |           |  |
| baltimore, | permit. Pages<br>Department of<br>Important: If it<br>any injury or o   |                   | * 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service-License   | ss of Facility Lo   | udoun Fu         | ineri  | Leesburg<br>al Chape                                  | e, Inc.                              |                      |  |  |           |  |
| iii.       | Physician<br>/Medical<br>Examiner   |                   | 23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  |   | n. Do not ento   | er the mode of dyir  | <u>'in Circl</u><br>ng, such as cardiac               | c or respiratory ar                  | rest,                | wig, VA  | Approximate<br>Interval Between<br>Onset and Death |           |  |
| , no,      |   | cal Examiner      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Creates at the state of the stat | Due to (or as a conseq  |                  |  |   |                                      | - 11                 |  |  |           |  |
| . Box og   | w requires that the death certificate be executed<br>been signed by the attending physician and<br>should be detached for use as the burial-transit | hysician/Medic    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | ic. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown | death 3          | Ectopic pregnancy<br>Other (specify)                         | 1   |                                      |                      | 23d. Date of delive                                | ery<br>Day Year                                    |           |  |
| cords, r   | The law requires that the<br>ate has been signed by th<br>page 2 should be detache  | by P              | Part II. Other significant conditions conf   | ributing to death but not res   | ulting in the un | derlying cause giv   | en in Part I.   | 23e. Did to                          |                      | .,   | ne cause of death?                                 |           |  |
|            | The larate has  | e Completed       | 25. Was case referred to medical   |   |                  |  |   | 1 Tyes                               | sy<br>med?<br>2 X No | prior to cor<br>death?                             | psy findings availa<br>mpletion of cause o<br>2 No | ble<br>of |  |
| 5          | ding Phy<br>n.<br>After this<br>funeral d   | To B              | examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | th (Check only or<br>ome 5 Resid<br>28d. Describe h   | lence (          | 6 □Other (Specify occurred                                   | y)  |                                      |                      |  |  |           |  |
|            | D S S S   | al Certification; |  |   |                  |  |   |                                      |                      |  |  |           |  |
|            | To the Hospital or within 24 hours after To the Funeral Dir completely filled in  | Medical           | (Check only 2 Medical Examin one)  29b. Signature and title of certifier   | er: On the basis of examinal and manner stated.   | tion and/or inv  | estigation, in my of   | pinion, death occur                                   | rred at the time, o                  | date and             | I place, and due to                                | the cause(s)                                       |           |  |
| ٧          | LANA  |                   |  | n leted cause of death (Item<br>CDR MC USN  | 23a) (Type, F    | 11111 20   | NAL NAVAL   | MEDICA                               | L CE                 | 9, 2005<br>ENTER                                   |  |           |  |
| 3          | Sta<br>Registr  |                   | 31. Date filed (Month, Day, Year)  | CDR MC USN 32. Register's Signa   |                  | <u>BETHE</u>   | SDA MD 20   | J889 <b>-</b> 5                      | 6UU_                 |  |  |           |  |

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TURNER 9:45 PM December 13 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LANHAM DOCTOR'S HOSPITAL PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 228-30-2430 23 1928 VIRGINIA MARCH Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exactine must be notified at 1 X Yes 2 □ No Director PRINCE GEORGE'S LANDOVER MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 6118 PARKWOOD ROAD 20785 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Mestin 2006. Elementary/Secondary (0-12) College (1-4or 5+) LABORER PRIVATE 6th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6118 PARKWOOD ROAD LANDOVER, MARYLAND 20785 CHANTEL DUCKETT/Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/19/2005 EMPORIA, VIRGINIA CHURCH CEMETERY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRAL VASCULAR ACCIDENT **Physician** /Medical Due to (or as a consequence of): Examiner HEPATITIS A S- uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed DEMENTIA Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¾ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director:

within 24 hours a To the Funeral I

hours after

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

6 Could not be determined

Demoron

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 🗌 Suicide

29a. Certifier

Medical

State Registrar

4 Thomicide



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year) 12/14/05

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D53718

|             |  |                  | 1 - For<br>State<br>Registrar  | State of M                                       |              | d / Depa                       |                          | t of H                 | lealth a                    |                    | , ,                                     | ene                                 | C.                    | 1.21.22  |
|-------------|--|------------------|--|--|--------------|--------------------------------|--------------------------|------------------------|-----------------------------|--------------------|---|-------------------------------------|-----------------------|--|
|             |  |                  | Registrar  1. Decedent's Name (First, Middle, L  | actl   |              | Cei                            | liliCali                 | e or i                 | Jean                        |                    | 2. Date of Death                        | g. No. UU                           | J                     | 4 C 4 C C                                      |
|             | Physici  | an               |  | ,  |              |                                |                          |                        |                             |                    | Month                                   | Day                                 | Year                  | 3. Time of Death                               |
|             | /Medic<br>Examir   | cal              | Berry Russell  4a. Facility Name (If not institution, g  |  |              |                                | 4b. City,                | Town, or               | Location o                  | f Death            | Decembe                                 | r 11, 2                             | 005<br>f Death        | 11:09 A.M                                      |
|             | LXamii   | 101              | Prince George  | s Hospital                                       | Cent         | er                             | Che                      | ever.                  | lv                          |                    |   | Prince                              |                       | orge!s   |
|             | Funeral  |                  |  | Sex 7. Ag  |              | ast birthday)                  | If Under<br>Months       |                        | If Under 2<br>Hours         | 24 Hrs.<br>Min.    | 8. Date of Birth<br>(Month, Day,        |                                     |                       | place (State or Foreign                        |
|             | Director   |                  | 579-36-8871  | 1 X 2 □ F  | 76           | Yrs.                           | Mortals                  | Duys                   | 110013                      | 1,411111           | 8/23/29                                 |                                     |                       | land   |
|             | and  |                  | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City    | , Town or Lo                   | cation                   |                        |                             |                    |   |                                     |                       | Od. Inside City Limits                         |
|             | Maryl<br>f sho   | ro               | Md.  | P.G.   |              |                                | Ch:                      | anel                   | Oaks                        |                    |   |                                     | -                     | 1 Yes 2 No                                     |
|             | r 28a  | rec              | 10e. Street and Number   | 1.0.   |              |                                | 10f. Zip                 |                        | oars                        |                    | 10                                      | g. Citizen of W                     | hat Cour              |  |
|             | 7 with   | Funeral Director | 5411 Duel Plac   | e  |              |                                |                          |                        | 20                          | 743                |   | U.S.                                | Α.                    |  |
|             | ems  | ner              | 11. Marital Status   | 12. Was Decedent<br>Armed Forces                 | Ever in U.   | S. 13.                         | Was Oeceo                | ent of Hi              | ispanic Orig                | in? (Spec          | cify Yes or No-<br>lican, etc.)         | 14. Race                            |                       | an Indian,                                     |
| 36          | or It  | by Fu            | 1 Never Married 2 Married  | 1 ☐ Yes <b>3/1</b> X<br>If Yes, Give             |              |                                | 1 ☐ Yes                  |                        |                             |                    | ,                                       | Specify:                            | Afr                   | ican-  |
| 21215-0036  | within 72 hours after death with the Maryland<br>ane.<br>than "natural", or items 23e or 28a-1 show<br>tra Marical Exc. ither . ust be notified at   | q pe             | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's   | Year or Dates:                                   |              | 16a. Dece                      | dont's Heur              | I Occup                | ation                       |                    |   | 6b. Kind of Bus                     | -                     | erican   |
| 7.          | n "na  | plet             | (Specify only highest of   | rade completed)                                  | - 1          | (Give                          | kind of wor<br>DO NOT us | rk done d              | during most                 | of workin          | 9 '                                     | ob. Kind of bus                     | 111022/111            | dustry   |
| 212         | d with<br>giene.<br>ir thai  | Completed        | Elementary/Secondary (0-12)  | College (1-4or                                   | 5+)          | $\mathbf{T}$                   | ruck I                   | Drive                  | er                          |                    |   | Constr                              | ucti                  | .on  |
|             | should be filed withir or Mental Hygiene. marked othar than imatic avant, The Mental Mental or M | Be C             | 17. Father's Name (First, Middle, La.  | st)  |              |                                |                          |                        | 18. Mother                  | r's Name           | (First, Middle, M                       | aiden Sumame                        | )                     |  |
| yla         | should band Ments marked   | 인                | James Thomas   |  |              |                                |                          |                        | Cor                         | nelia              | a Lee                                   |                                     |                       |  |
| Maryland    | 2 she and lamb   |                  | 19a. Informant's Name/Relationship   |  |              |                                |                          |                        |                             |                    | Route Number,                           | -                                   |                       | -  |
|             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if itam 27 Is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic avant, the Maxical Examination ust be notified at any injury or other traumatic avant, the Maxical Examination ust be notified at angue.  |                  | Pricilla Thomas  20a. Method of Disposition  | /Sister  | 20h Pi       | 7410                           | Good                     | land                   | Dr.                         | # 3,1              | Landover                                | Md. 2                               |                       |  |
| Baltimore,  | permit. Pages 'Department of H<br>Important: If its<br>any injury or ot<br>once.   |                  | t√Surial 2 ☐ Cremation 3   | Removal from State                               |              | lace of Dispo                  |                          |                        |                             |                    |   |                                     | •                     |  |
| 臣           | artme<br>artme<br>ortani<br>injury   |                  | <ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>  |  | ML           | Oliv                           |                          |                        | s of Facility               |                    | /05 W                                   | lashingt                            | on,                   | D.C.   |
| Ba          | permi<br>Depa<br>Impo<br>any ii  |                  | and the second s | V. Osas  | 1            | -                              | H.S.W                    | ashi                   | ngton                       | & Sc               | ons Co.,                                | Inc.                                | _                     | .C. 20019 _                                    |
|             | ₩.   |                  | 23a. Part1. Enter the dise se, or co   | mplications that cause                           | d the death  | . Do not ent                   | er the mode              | urro<br>e of dying     | ugns d                      | AVE.<br>cardiac or | respiratory arre                        | shingto                             | n,D.                  | Approximate                                    |
|             | Physician  |                  | shock, or heart failure. List on<br>Immediate Cause (Final   | y one cause on each i                            | ^            | MYE                            | IDM.                     | 4                      |                             |                    |   |                                     |                       | Interval Between<br>Onset and Death            |
|             | /Medical   |                  | disease or condition resulting in death)   | a. Que to (or as                                 | a consequ    | MYE uence of):                 |                          |                        |                             |                    |   |                                     |                       |  |
|             | Examiner   |                  | Sequentially list conditions   | b. KENAL   | - F          | AILU;                          | RE_                      |                        |                             |                    |   |                                     |                       |  |
|             | Sit 9d   | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | Due to (or as                                    | a consequ    | ence of):                      |                          |                        |                             |                    |   |                                     |                       |  |
|             | and<br>L-tran  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last  | c<br>Due to (or as                               | a consequ    | ience of):                     |                          |                        |                             |                    |   |                                     |                       |  |
| 8760,       | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | icalE            |  | d  | ,            |                                |                          |                        |                             |                    |   |                                     |                       |  |
| 687         | ificate<br>g phys  |                  |  | d  |              |                                |                          |                        |                             |                    |   | -                                   |                       |  |
| Вох         | eath certific<br>attending pl  | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome                             |              |                                | 75-1                     |                        |                             |                    |   | , 23d. Date                         | of delive             | ory  |
|             | deatl  | icia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1□Live birth<br>4□Pregnant a<br>9□Unknown        |              |                                | Ectopic pro<br>Other (sp |                        |                             |                    |   | Mont                                | h                     | Day Year                                       |
| P.O.        | at the   | hys              | 9 🔲 Unknown  |  |              |                                |                          |                        |                             |                    |   |                                     |                       |  |
|             | res that the de<br>signed by the a<br>be detached f  | by               | Part II. Other significant conditions  | contributing to death b                          | out not resu | Ilting in the u                | nderlying ca             | ause give              | en in Part I.               |                    |   |                                     |                       | ne cause of death?                             |
| ord         | w requir<br>been si<br>should I  | ted              |  |  |              |                                |                          |                        |                             | _                  | 1 L Yes                                 | 2 □ No 3                            | Prob                  | ably 4 Unknown                                 |
| Records,    | has b  | Completed        |  |  |              |                                |                          |                        |                             |                    | 24a. Was an<br>autopsy<br>perform       | pri                                 | or to cor             | psy findings available<br>apletion of cause of |
| a           | n: Th<br>licate<br>r, pag  |                  |  |  |              |                                |                          |                        |                             |                    |   |                                     | ath?<br>] Yes         | 2 🗆 No   |
| Vital       | siciar<br>certif<br>irecto   | o Be             | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | Hospital:  |              |                                |                          | A Othe                 | \r:                         |                    | (Check only one                         |                                     |                       |  |
| Division of | Attanding Physician: The rigeath. actor: After this certificate hactor. After this certificate hay the funeral director, page  |                  | 1 ☐ Yes 2 ▼ No  27. Manner of Death  | 1 ☐ Inpation                                     | - / \        | ER/Outpatien<br>28b. Time of   |                          | 8c. Injury<br>Work     | 4 🔲 Nui.                    |                    | e 5 Resider                             |                                     |                       | )  |
| ion         | nding<br>ath.<br>r: Afte<br>e fun  | atlo             | 1 X Natural 5 ☐ Pending<br>2 ☐ Accident investigat   |  | ly Year)     | Injury                         | М                        |                        | (?<br>Yes 2 □ N             | lo                 |   |                                     |                       |  |
| Vis         | r Atta<br>er de:<br>racto<br>by th   | Certification:   | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine  |  | jury - At ho | me, farm, str                  | eet, factory             | , office               |                             | 21                 | Bf. Location (Stre<br>City or Town,     |                                     | or Rura               | l Route Number,                                |
|             | rs afte<br>al Dira   | Cer              | locate Control | 11   | (            | ,                              |                          |                        |                             |                    |   |                                     |                       |  |
|             | To tha Hospital or Attand within 24 hours after death To the Funaral Diractor: completely filled in by the   | edical           | 29a. Certifier (Check only one)  12 Certifying I   | hysicien: To the best<br>iminer: On the basis of | of examinat  | viedge, death<br>ion and/or in | occurred a vestigation,  | at the tim<br>in my op | e, date and<br>inion, death | place, ar          | nd due to the cau<br>d at the time, dat | use(s) and manue<br>e and place, an | ner as st<br>d due to | ated.<br>the cause(s)                          |
|             | To tha within 2 To the Complet   | Med              | 29b. Signature and title of certifier  | and manner st                                    | ated.        |                                | 29c                      | . License              | number                      |                    | 29                                      | d. Date signed                      | Month,                | Day, Year)                                     |
| )           | F≥Fö   |                  |  |  |              |                                |                          |                        | 5818                        | 2                  |   | 12.14                               |                       | •  |
|             |  |                  | 30. Name and address of thron wh   | completed cause of o                             | death (Item  | 23a) (Type.                    | Print)                   |                        | 010                         | ~                  |   | 15. 17                              |                       |  |
|             |  |                  | C. Donald George   | M.D. 3001  | Hosp         | ital I                         | rive.                    | Chev                   | erly.                       | Mar                | vland 2                                 | 0785                                |                       | oolthill                                       |
|             | Sta  |                  | 31. Date filed (Month, Day, Year) DEC 1 6 20   | Registr  | rar's Signat | ure di                         | Les .                    |                        | 4-1                         |                    |   |                                     |                       |  |
|             | Registr  | ar               | DEC 1 0 70   | US JUNE  | <i>J</i> /#. | 1                              |                          |                        |                             |                    |   |                                     |                       |  |

|  |  |                  | For State Registrer   | ate of Man   | yland / Depa<br><i>Cer</i>             | rtment of H                                  |  |  | giene 005  | 42423  |
|--|--|------------------|---|--|--|--|--|--|--|--|
|  | Physici  | an               | 1. Decedent's Name (First, Middle, Last) Sarah Eliza  | heth   | Thom                                   | a s  |  | 2. Date of Dea                             | 1, Day 2005 Year                                 | 3. Time of Death 2:50 p M                            |
|  | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, give stree   |  | 1110111                                |  | Location of Death                              |  | 4c. County of Death                              |  |
|  |  |                  | Civista Medical Cen  5. Social Security Number 6. Sex   |  | In yrs. last birthday)                 | LaPlata,                                     | MD If Under 24 Hrs.                            | C Date of Birth                            | Charles  | (2)  |
|  | Funeral<br>Director  |                  | 2 1 4 - 5 8 - 0 8 2 2   |  | 55 Yrs.                                | Months Days                                  | Hours Min                                      | 8. Date of Birth<br>(Month, Day<br>Sept 18 | , Year) 9. Birti<br>Col<br>, 1950 Mar            | iplace (State or Foreign<br>intry)<br>y land         |
|  | land ow  |                  | Usual Residence of Decedent  10a. State 10b. County   | 10   | Oc. City, Town or Lo                   | cation                                       |  |  |  | 10d. Inside City Limits                              |
|  | e Mary<br>la-f sh  | ctor             | Md. Charles   |  | Nanjemo                                | У  |  |  |  | 1X Yes 2 □ No  |
| M  | with the   | Funeral Director | 10e. Street and Number  | D1   |  | 10f. Zip Code                                |  |  | 10g. Citizen of What Co                          | intry?   |
| 3  | death<br>rms 23  | neral            |   | Vas Decedent Eve   | er in U.S. 13. V                       | 20662<br>Vas Decedent of H                   | ispanic Origin? (Spe<br>In, Mexican, Puerto    | ecity Yes or No-                           | U S<br>14. Race - Amer                           |  |
| 36   | rurs after death with the Marylar<br>el', or Items 23e or 28a-f show<br>Examiner must be notified at   | by Fu            | 1 Never Married 2 Married 1   | Armed Forces?  Yes 24 No Yes, Give Year or Dates:              |  | ☐ Yes 2 No                                   |  | Hican, etc.)                               | Specify Bla                                      |  |
| 7/200  | 72 hours<br>"neturel",<br>dicel Eve  | ted k            | 15. Decedent's Educatio (Specify only highest grade cor   |  | 16a. Deced                             | ent's Usual Occup                            | ation  | ing  | 16b. Kind of Business/l                          |  |
| 121  | within 7   | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5+)   |  | ewife  | during most of worki<br>)                      | , ing                                      | Orm Home   |  |
| 1 2 br   | be filed<br>ttal Hygie<br>d other<br>event, tt   | Be Co            | 12. Father's Name (First, Middle, Last)   | 0  | nous                                   | ewile  | 18. Mother's Name                              |  |  |  |
| ylar   | S should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel", or Items 23e or 28a-1 show sumatic event, the Medical Examinating the notified at  | To               | Daniel Lawson   | 200  | 101 11 71                              |  | Mamie  |  | ardson   |  |
| Mai  |  | T 8              | 19a. Informant's Name/Relationship (Туре, F<br>Bryon Lawson/Son   | rint)  |  |  |  |  | r, City or Town, State, Z.<br>nie, Md. 2         |  |
| ore,   | Pages 1 and 3<br>nent of Health<br>snt; If item 27<br>ury or other tr  |                  | 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Remo   |  | 20b. Place of Dispos<br>cemetery, crem | sition (Name of<br>natory or other place     | e)   | Date                                       | 20c. Location - City or 1                        | own, State   |
| 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityBluford Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, |  |                  |   |  |  |  |  |  |  |  |
|  |  |                  |   |  |  |  |  |  |  |  |
|  | Physician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a c  |  | Can  | cer  |  |  |  |
|  | Examiner   | J.               | Sequentially list conditions, b. —  | Due to (or as a c  |  |  |  |  |  |  |
|  | uted<br>d<br>ansit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause to issues or injury that initiated events c. | Due to (or as a co   | orisequence or):                       |  |  |  |  |  |
| 90,  | ate be executed<br>hysician and<br>the burial-transit  | I Exa            | resulting in death) Last  | Due to (or as a co   | onsequence of):                        |  |  |  |  |  |
| 6876   | ficate to physical distribution of the physic | edical           | d   |  |  | -  |  |  |  |  |
| Box 68760,   | leath certifica<br>attending ph<br>I for use as th   | Physician/Med    | in the past 12 months?  | f yes, outcome of p  | Fetal death 3                          | Ectopic pregnancy                            |  |  | 23d. Date of deliv                               | rery<br>Day Year                                     |
| P.O. I   | at the dea<br>by the a<br>tached f   | hysic            | 1 Vec 2 No  | I□Pregnant at tim<br>□□Unknown                                 | ne of death 5                          | Other (specify)                              |  |  |  |  |
|  | es tha   | by               | Part II. Dther significant conditions contribu  | iting to death but n   | not resulting in the ur                | derlying cause give                          | en in Part I.                                  |  | bacco use contribute to<br>es 2 ☑No 3 ☐ Pro      |  |
| Division of Vital Records,   | aw requir<br>is been si<br>2 should l  | Completed        |   |  |  | <u> </u>                                     |  | 24a. Was a                                 | an 24b. Were aut                                 | opsy findings available                              |
| Re   | The is   | Com              |   |  |  |  |  | autops<br>perform                          | med? death?                                      | ompletion of cause of<br>2 \( \subseteq \text{No} \) |
| Vita   | sician; Th<br>certificate<br>irector, pag  | Be               | 25. Was case referred to medical examiner?  1 Yes 2 No Hospi  | tal: 1 Vinpatient  | 2 ER/Outpatient                        | 2□ DOA Othe                                  | 26. Place of Death                             |  | ne)<br>ence 6 Other (Spec                        | 4.1  |
| n of   | ding Phys<br>h.<br>After this<br>funeral di  | on: To           |   | Ba. Date of Injury<br>(Month, Day Ye                           |  | 28c. Injun                                   |  |  | ow injury occurred                               | 19)  |
| isio   | death.<br>death.<br>ctor; A<br>y the fu  | ertification:    | 2 Accident investigation 3 Suicide 6 Could not be   | Re. Place of Injury  | - At home, farm, stre                  |  | Yes 2 □ No                                     | 28f. Location (S                           | treet and Number or Rui                          | al Route Number                                      |
| Div  | tel or At<br>rs after d<br>el Direct<br>ed in by   | Certi            | 4 Homicide determined   | building, etc. (   | Specify)                               |  |  | City or Town                               | n, State)  |  |
|  | To the Hospitel or a within 24 hours after To the Funerel Direct completely filled in b  | dical            | 29a. Certifier 1  Certifying Physicia (Check only one) 2  Medical Examiner:   | n: To the best of m<br>On the basis of ex<br>and manner stated | amination and/or inv                   | occurred at the time<br>estigation, in my of | ne, date and place, a<br>pinion, death occurre | and due to the c<br>ed at the time, d      | ause(s) and manner as<br>late and place, and due | stated.<br>to the cause(s)                           |
|  | To the vithin To the comple  | Me               | 29b. Signature and title of certifier  Mah.   | 29d. Date signed (Month, Day, Year) 12   12   2005             |  |  |  |  |  |  |
| CR   | (3)  |                  | 30. Name and address of person who comple   | eted cause of deat   | h (Item 23a) (Type, i                  |  |  | C 3/5                                      |  |  |
|  | Sta  | te               | Nalin Mathur, MD, 10 31. Date filed (Month, Day, Year)  |  |  |  | 4, Waldor                                      | i, MD 2                                    | 0603   |  |
|  | Registr  | ar               | 31. Date filed (Month, Day, Year)  BEC 1 5 2005   | Men  | N. Rose                                |  |  |  |  |  |

|   |  |                  | 1 - For<br>State<br>Registrar   | State of M  | Maryland                        |                             | artment of<br>rtificate of            |                      |  |                                  | giene<br>Reg. Nb.               | 05  | 42421   |          |
|---|--|------------------|---|---|---------------------------------|-----------------------------|---------------------------------------|----------------------|--|----------------------------------|---------------------------------|---|---|----------|
|   | Physici  | an               | 1. Decedent's Name (First, Middle   | e, Last)  |                                 |                             |                                       |                      |  | 2. Date of Dea                   | ath<br>Day                      | Year  | 3. Time of Deat                                     | 1        |
|   | /Medic   | al               | James   | George  |                                 | Ti                          | shok                                  |                      |  | Decembe                          |                                 | 2005  | 7:30 A  | М        |
|   | Examin   | er               | 4a. Facility Name (If not institution 1012 Kenneth S  |   | r)                              |                             | 4b. City, Town                        | n Head               |  |                                  |                                 | nty of Death                                |   |          |
|   | Funeral  |                  | 5. Social Security Number   | 6. Sex 7. A   | ge (In yrs. la                  | st birthday)                | If Under 1 Yea                        | r If Under           | 24 Hrs   | 8. Date of Birt                  | <b>b</b>                        | narles<br>9. Birth                          | place (State or Fore                                | eign     |
| Н   | Director   |                  | 174-38-9654   | 1 XM 2 F  | 58                              | Yrs.                        | Months Day                            | s Hours              | Min.   | Month, Day                       | $\frac{y, Year)}{1947}$         | Cou   | sylvania  |          |
|   | and **   |                  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City.                      | Town or Lo                  | ecation                               |                      |  |                                  |                                 |   | 10d. Inside City Lim                                | ite      |
|   | Maryl<br>f sho   | ro               | Maryland Char   | 100   | ,                               | dian                        |                                       |                      |  |                                  |                                 |   | 1 X Yes 2   |          |
|   | n the  | Directo          | 10e. Street and Number  | 163   | 111                             | ulali                       | 10f. Zip Code                         |                      |  |                                  | 10g. Citizen o                  | of What Cou                                 | ntry?   |          |
|   | 23e c  | al D             | 1012 Kenneth S  | treet   |                                 |                             | 2064                                  | 0                    |  |                                  | ι                               | J.S.A.                                      |   |          |
|   | er dez   | Funeral          | 11. Marital Status  | 12. Was Deceden<br>Armed Forces                                       | ? 106                           | . 13. Y                     | Was Decedent of<br>If Yes, specify Cu | Hispanic Ori         | igin? (Spec  | ify Yes or No-<br>ican, etc.)    | 14. F                           | Race - Ameri                                |   |          |
| 36  | 72 hours after death with the Maryland<br>naturel', or items 23e or 28e-f show<br>dicel Examinar must be notified at       | by F             | 1 Never Married 2 Marr<br>3 Widowed 4 Divorced  | ied 1 X Yes 2 If Yes, Give<br>Year or Dates                           | 106                             | J-                          | 1 ☐ Yes 2 ☐XN                         |                      |  |                                  | Spe                             | cify:                                       |   |          |
| 21215-0036                                    | 2 hou  | ted              | 15. Deceden   | t's Education   |                                 | 16a. Deced                  | dent's Usual Occi                     | upation              |  |                                  | 16b. Kind of                    | W/1<br>f Business/In                        | ite<br>ndustry                                      |          |
| 218   | within 7<br>ene.<br>than "n  | Completed        | (Specify only highes<br>Elementary/Secondary (0-12)   | completed) College (1-4or   | 5+)                             | (Give<br>life. i            | kind of work don<br>DO NOT use retir  | e during mos<br>red) | t of working   | 9                                |                                 |   |   |          |
| 2   | filed wi<br>Hygien<br>other th   | Con              | 12  |   |                                 | Mach <sup>.</sup>           | ine Oper                              |                      |  |                                  |                                 |   | ufacturer   | ٠ا       |
| and   | ntal H<br>ed otl   | Be               | 17. Father's Name (First, Middle,   | Last)   |                                 |                             |                                       |                      |  | First, Middle,                   | Maiden Sum                      | ате)  |   |          |
| Maryland                                      | should be<br>and Mental<br>marked of<br>umatic ev  | 2                | _Metro_Tishok<br>19a. Informant's Name/Relations.   | hìo (Type, Print)   | -                               | 19h Mailir                  | ng Address (Stree                     |                      | Date   |                                  | r City or Toy                   | en State Zie                                | Code)   |          |
|   | d 2 th a 7 is trait  |                  | Darla Jean Tis  |   |                                 |                             |                                       |                      |  |                                  |                                 |   | nd 20640  | 1        |
| Jre,  | of Health<br>item 27   |                  | 20a. Method of Disposition  | • •   | 20b. Pla                        | ice of Dispo                | sition (Name of<br>natory or other pi | lace)                | Da   |                                  | 20c. Locatio                    |   |   |          |
| <u><u>E</u></u>                               | Pages<br>ment of<br>ant: If it   |                  | 1 ♥ Burial 2 □ Cremation  1 □ Donation 5 □ Other (S   | 3 ∐Removal from Stati<br>pecify)                                      | 9                               |                             | e Cemete                              |                      | 2-19-  | 2005                             | Ebensb                          | ourg.                                       | Pennsylva   | nia      |
| Baltimore,                                    | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>eny injury or other<br>once.                           |                  | 21. Signature of Funeral Service  | Name and Add  | ress of Facilit<br>ERAL H       | <sup>™</sup> P.O.<br>OME,   | BOX 150<br>3035 0                     | 6, WAL<br>LD WAS     | DORF,  | MD 20604                         |                                 |   |   |          |
| 8760,   | Physician   Medical   Physician and attending physician and lor use as the burial-transit                                  | dical Examiner   | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a   | s a conseque                    | ence of):                   | er the mode of dy                     | ring, such as        | All de la constant de | respiratory and                  | rest,                           |   | Approximate Interval Between Onset and Death        |          |
| 9   | ding p   | /Mec             | IF FEMALE:  | 23c. If yes, outcom-  | e of pregnant                   | PM C                        |                                       |                      |  |                                  |                                 |   |   |          |
| .O. Box                                       | 000  | by Physician/Med | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 1 Live birth 4 Pregnant a   | 2 Fetal d                       | leath 3                     | Ectopic pregnant<br>Other (specify)   | су                   |  |                                  |                                 | Date of delive<br>Month                     | ery<br>Day Year                                     |          |
| s,<br>P                                       | es that<br>igned b   | by Pl            | Part II. Other significant condition  | ns contributing to death  | but not result                  | ing in the ur               | nderlying cause g                     | iven in Part I.      |  | 23e. Did to                      | bacco use co                    | intribute to th                             | he cause of death?                                  |          |
| ğ   | w require<br>been sig<br>should b  |                  |   |   |                                 |                             |                                       |                      |  | 1 □ Y                            | es 2 No                         | 3 ☐ Prob                                    | pably 4 Unknow                                      | vn       |
| al Record                                     | The lar  | Completed        |   |   |                                 |                             |                                       |                      |  | 24a. Was a autops perfor         | Sy                              | D. Were auto<br>prior to condeath?<br>1 Yes | psy findings availat<br>mpletion of cause o<br>2 No | ole<br>f |
| 25. Was case referred to medical examiner?  1 |  |                  |   |   |                                 |                             |                                       |                      |  | -                                |                                 |   |   |          |
|   |  |                  |   |   |                                 |                             |                                       |                      | d. Describe h  |                                  |                                 | y)  |   |          |
| ion   | Attending Pher death.  | atio             | 1 V atural 5 Pending<br>2 Accident investig   | 9   | ay rear)                        | Injury                      |                                       | ork?<br>∐Yes 2.∐t    | No   |                                  |                                 |   |   |          |
| Division of                                   | To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune. | Certification;   | 3 Suicide 6 Could r<br>4 Homicide determi   | ned 289. Place of it  | njury - At hom<br>tc. (Specify) | e, farm, stre               | eet, factory, office                  | )                    | 28   | f. Location (Si<br>City or Town  | treet and Nun<br>n, State)      | nber or Rura                                | l Route Number,                                     |          |
|   | To the Hospitel or within 24 hours after To the Funerel Discompletely filled in  | edical           | 29a. Certifier 1 Certifyin (Check only one)   | g Physicien: To the best<br>Examiner: On the basis of<br>and manner s | of examinatio                   | edge, death<br>n and/or inv | estigation, in my                     | opinion, deat        | d place, an<br>th occurred   | d due to the c<br>at the time, d | ause(s) and r<br>late and place | nanner as st                                | tated.<br>the cause(s)                              |          |
| .**   | To To con  | 2                | 29b. Signature and title of certifier   | e Seuthet   |                                 |                             | DO                                    |                      | 031  | 2                                | 12/14                           | Nonth.                                      | Day, Year)  |          |
| 3   | RHSI   |                  | 30. Name and address of person  | who completed cause of  | death (Item 2                   | (Type, I                    | Print)                                | 7/5/                 | 214  | ling                             | 000                             | 1 - 0                                       | inia ldice  | FI       |
|   | Sta  | te               | 31. Date filed (Month, Day, Year)   |   | rar's Signatu                   |                             | 100                                   | 10                   | UILI   | 11111                            | UII                             | 17 (  | AND ICA   | 10CF     |
|   | Registra   |                  | DEC 1   | 2005  | 1000 S                          | K A                         | mile                                  |                      |  |                                  |                                 |   | 1001.00   |          |
| DH  | MH 17 Rev 1/20   | 01               |   | 7   |                                 | 1                           |                                       |                      |  |                                  |                                 |   |   | -        |

|  |   |                  | For State Registrar   | State of                                   | f Marylan                        |                              | artment of H                                   |                             | d Mental Hy                                 | giene                            | 05                    | 42425  |
|--|---|------------------|---|--|----------------------------------|------------------------------|--|-----------------------------|---|----------------------------------|-----------------------|--|
|  | , <u>%</u> (  | 1                | Decedent's Name (First, Middle  | , Last)                                    |                                  |                              |  |                             | 2. Date of De                               | aath                             |                       | 3. Time of Death                                   |
|  | Physici<br>/Medic   |                  | Dorothy A. 7  | Ceagle                                     |                                  |                              |  |                             | DECEN                                       | BER 16                           | Year<br>2005          | - 11:55 PM   |
|  | Examin  |                  | 4a. Facility Name (If not institution,  | give street and nun                        | nber)                            | 3                            | 4b. City, Town, or                             | Location of E               | Death                                       |                                  | ty of Death           |  |
|  |   | 1000             |   | INGTON ME                                  |                                  | ENTER                        | GLEN I   | If Under 24                 |   | ANNU                             |                       | UNDEL  |
|  | Funeral Director  |                  | 5. Social Security Number 220-32-7778   | 6. Sex<br>1 ☐ M 2 🛣 F                      | 7. Age (In yrs.<br>67            | Yrs.                         | Months Days                                    |                             | Min. 8. Date of Bir (Month, Date 23         | 1937                             | Cou                   | place (State or Foreign<br>Intry)<br>ISylvania     |
| 100  | W.5   |                  | Usual Residence of Decedent   |  |                                  |                              |  |                             | DCC-25                                      | ,1007                            | 1 01111               |  |
|  | nylan<br>show   | _                | 10a. State 10b. County  |  | 10c. Cit                         | ty, Town or Lo               | ocation  |                             |   |                                  |                       | 10d. Inside City Limits                            |
|  | 8a-1  | octo             |   | hester                                     |                                  | Hurlo                        | 1  |                             |   |                                  |                       | 1 ☐ Yes 2 ☑ No                                     |
|  | with ti   | Dire             | 10e. Street and Number 4346 Russe1  | 1 Road                                     |                                  |                              | 10f. Zip Code                                  | .643                        |   | 10g. Citizen o                   |                       | •  |
|  | hours after death with the Maryland<br>ural, or Iteme 23a or 28a-f ehow<br>Il Exacili of must be ricilified at  | Funeral Director | 11. Marital Status  |  | dent Ever in U                   | .S. 13.                      |  |                             | ? (Specify Yes or No                        |                                  |                       | ican Indian,                                       |
| (0   | or Item   | Fun              | 1 ☐ Never Married 2 🖫 Marri   | Armed For<br>ed 1 ☐ Yes                    | rces?<br>2 <b>√</b> ∑No          |                              |  |                             | ? (Specify Yes or No<br>Juerto Rican, etc.) |                                  | lack, White           | , etc.   |
| 93   | rali, o   | by               | 3 Widowed 4 Divorced  | If Yes, Giv<br>Year or Da                  | e<br>ates:                       |                              | 1 ☐ Yes <b>X</b> □XNo                          | Specify:                    |   | Spec                             | ify: B                | lack   |
| >-5  | "natural",  | Completed        | 15. Decedent<br>(Specify only highes  |  |                                  | (Give                        | dent's Usual Occupa<br>kind of work done of    | luring most of              | working                                     | 16b. Kind of                     | Business/Ir           | ndustry  |
| 2121   | filed within 72<br>Hygiene.<br>ther then "na<br>int, It e Medic   | mo               | Elementary/Secondary (0-12)   | College (1                                 | -4or 5+)                         |                              | DO NOT use retired,<br>tile San                |                             |   | E.I.                             | DuPo                  | nt   |
| 2 p  | filled<br>Hygid<br>other  | e Co             | 17. Father's Name (First, Middle, I   | _ast)                                      |                                  |                              |  |                             | Name (First, Middle                         | , Maiden Sumi                    | ame)                  |  |
| TEAGUE 、)のAMT HY<br>Baltimore, Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours aft to Health and Mental Hyghers.  If Item 27 is marked other than "natural", or or other traumatic event, Ite Medical Exercises. | To Be            | John Wesley   | Adams, S                                   | Sr.                              |                              |  | Dorot                       | thy Eliz                                    | abeth                            | Brac                  | kett   |
| ary -  | and N   |                  | 19a. Informant's Name/Relationsh  |  |                                  | 19b. Mailir                  | ng Address (Street a                           | ind Number o                | or Rural Route Numb                         | er, City or Tow                  | n, State, Zi          | ip Code)   |
| AGLE ore, Ma                                       | ss 1 and 2<br>of Health<br>Item 27 I  |                  | Ronald W. Ad  | ams/Son                                    |                                  |                              |  | -                           | Dr., D                                      |                                  |                       |  |
| A Ore  | ges 1<br>t of H<br>if Iter<br>or oth  |                  | 20a. Method of Disposition  15 Burial 2 Cremation   | 3 Removal from                             |                                  |                              | sition (Name of<br>matory or other place       |                             | Date  | 20c. Location                    | -                     |  |
| Limit<br>time                                      | tmen<br>tant:<br>njury  |                  | 4 □ Donation 5 □ Other (Sp  |  | Jo                               |                              | emetery  |                             |   |                                  |                       | Maryland   |
| Bal  | permit. Pages<br>Department of i<br>Important: If It<br>any injury or o   |                  | 21. Signature of Funeral Service I  | 7. Est                                     | ew                               | 22                           | $16$ N $_{*}$ Ma $_{*}$                        | s of Facility E<br>iin St   | Framptom<br>Fede                            | Funer<br>ralsbu                  | al H                  | ome, P.A.<br>MD 21632                              |
|  |   |                  | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that conty one cause on e    | aused the deat<br>ach line.      | h. Do not ent                | er the mode of dying                           | g, such as car              | rdiac or respiratory a                      | ırrest,                          |                       | Approximate<br>Interval Between<br>Onset and Death |
|  | Physician   |                  | Immediate Cause (Final disease or condition resulting in death)   | a. Av                                      | NOXIC                            | ENCE                         | shalo  | Hod                         | $\sim$                                      |                                  |                       | day  |
| 7  | /Medical<br>Examiner  |                  | resulting in death)   | Due to (                                   | or as a conseq                   | juence of):                  |  | 1                           | 7   |                                  |                       | . 3  |
|  | . %   | e.               | Sequentially list conditions if any, leading to immediate   | b. Due to (                                | or as a conseq                   | ruence of):                  |  |                             |   |                                  | 11                    |  |
|  | uted<br>d<br>ansit  | Examine          | Sacuentially list anothions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |  |                                  |                              |  |                             |   |                                  |                       |  |
| 0,   | sicien and<br>burial-transit  | Exa              | resulting in death) Last  | Due to (                                   | or as a conseq                   | uence of):                   |  |                             |   |                                  |                       |  |
| 3760,  | # ≥ e   | cal              |   | d  |                                  |                              |  |                             |   |                                  |                       |  |
| 89 x   | The law requires that the death certifical sie hes been signed by the ettending phypage 2 should be detached for use as the   | by Physician/Med | IF FEMALE:  | 000 16.000                                 |                                  |                              |  |                             |   |                                  |                       |  |
| Вох  | ettenc<br>for us  | lan/             | 23b. Was decedent pregnant in the past 12 months?   |  | inth 2 ∏Feta<br>ant at time of d | il death 3 [                 | Ectopic pregnancy Other (specify)              |                             |   |                                  | ate of deliv<br>Jonth | rery<br>Day Year                                   |
| P.O.   | that the de<br>led by the e<br>detached t   | yslc             | 1 □ Yes 2 X No<br>9 □ Unknown   | 9□ Unkno                                   |                                  | 194(1) 5                     |  |                             |   |                                  |                       |  |
|  | s that<br>ned b   | y Pt             | Part II. Other significant condition  | ns contributing to de                      | eath but not res                 | ulting in the u              | nderlying cause give                           | n in Part I.                | 23e. Did                                    | tobacco use co                   | ntribute to           | the cause of death?                                |
| rds  | w requires that<br>been signed I<br>should be det   | ed b             | Stroke  |  |                                  |                              |  |                             | 1 🗆   | Yes 2□No                         | 3 🗆 Pro               | bably 4 Unknown                                    |
| o<br>O   | aw re   | plet             | - Husertens   | Sign                                       |                                  |                              |  |                             | 24a. Was                                    | an 24b                           | . Were aut            | opsy findings available                            |
| ĕ  | The law<br>cete hes<br>page 2   | Completed        | Richetes  |  |                                  |                              |  |                             |   | ormed?<br>2\12\100               | death?                | _  |
| /ita   | ician: Th<br>certificete<br>rector, pag   | Be               | 25. Was case referred to medical examiner?  | 11   |                                  |                              | I ou   |                             | Death   Check only                          | one                              |                       |  |
| Division of Vital Records,                         | iding Physician:<br>th.<br>: After this certifice<br>funeral director, p  | 1°               | 1 Yes 2 No  |  |                                  | ER/Outpatier<br>28b. Time of |  | 4   Nursi                   | ng Home 5 Res                               | how injury occ                   |                       | ify)   |
| LO CO  | ding<br>h.<br>After<br>funer  | ig<br>ig         | 1 Natural 5 ☐ Pending   | 9  | of Injury<br>h, Day Year)        | Injury                       | Work   | al<br>?<br>∕es 2∐No         |   | now injury occ                   | med                   |  |
| isi  | Attending r death. ector: After by the funer  | flca             | 3 ☐ Suicide 6 ☐ Could n   | ot be 28e, Place                           | of Injury - At h                 | ome, farm, str               | reet, factory, office                          |                             | 28f. Location                               |                                  | nber or Rui           | ral Route Number.                                  |
| ă  | al or after   | Certification;   | 4 Homicide  | buildir                                    | ng, etc. <i>(Specil</i>          | <b>(y</b> )                  |  |                             | City or To                                  | wn, State)                       |                       |  |
|  | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | edical (         | 29a. Certifier 1 Certifyin (Check only one)   | g Physician: To the<br>Examiner: On the ba | asis of examina                  | owledge, death               | h occurred at the tim<br>vestigation, in my op | e, date and pointion, death | place, and due to the occurred at the time, | cause(s) and r<br>date and place | nanner as :           | stated.<br>to the cause(s)                         |
|  | vithin<br>Fo the  | Me               | 29b. Signature and title of certifier   |  |                                  |                              | 29c. License                                   | number                      |   | 29d. Date sign                   | ned (Month            | , Day, Year)                                       |
|  | - 31- 0   |                  | b Carl  | 01110                                      | 118                              |                              | M  | 1599                        | 119   | Neces                            | 1601                  | 17 2ME   |
|  |   |                  | 30. Name and addres of poson  |  | of death (Iter                   | п 23а) (Туре,                | Print)   |                             | -   | Decor                            | NI                    | The second   |
|  |   |                  | 301 Hospita   | I Dr                                       | 6leu                             | Bur                          | MIR, 21  | 061                         | _,  | ulus                             | Pho                   | un MD  |
| المرابع المرابع                                    | Sta<br>Registr  |                  | 31. Date filed (Month, Day Year)  |  | egistrar's Signa                 | ature                        |  | `                           |   |                                  |                       | )  |
| 1  | negisti   | ш                | DEC 2 0 2   | 005  | 2.31.20 As                       | 6 AAM                        | A. S. S. S. S. S. S. S. S. S. S. S. S. S.      |                             |   |                                  |                       |  |

Vida L. Tate 05-08585 NJM

| Physici<br>/Media<br>Examir<br>Funeral<br>Director   | cal                | 1 - State Registrar  1. Decedent's Name (First, Middle, La  Vida Lea Tate  4a. Facility Name (If not institution, give  |   | -  | ertificate                      |                                   |                          | 2. Date of Deat                                      | eg. No.                | 700                       | 3. Time of Death                            |
|--|--------------------|---|---|--|---------------------------------|-----------------------------------|--------------------------|--|------------------------|---------------------------|---|
| /Medic<br>Examin   | cal                | Decedent's Name (First, Middle, La Vida Lea Tate     A. Facility Name (If not institution, given the content of the conte |   |  |                                 |                                   |                          |  |                        | _Year_                    |   |
| /Medic<br>Examin   | cal                | 4a. Facility Name (If not institution, given  |   |  |                                 |                                   |                          | - MOHILI   | Day o                  | Teal                      |   |
| Funeral<br>Director  |                    |   |   |  |                                 |                                   |                          | Decembe:   | r 19, 2                | 005                       | 12:51 A                                     |
| Director   |                    |   |   |  | ,                               |                                   | ation of Death           |  | 4c. County             |                           | 1 4   |
| Director   |                    | Anne Arundel Medi   |   |  | Annap                           |                                   |                          |  | Anne .                 |                           |   |
| D.   |                    | 212-42-0449   | Sex<br>1 □ M 2 X F 6 2  | e (In yrs. last birthday<br>Yrs.                           | Months 1                        |                                   | urs Min.                 | 8. Date of Birth<br>March Days                       | 3 <sup>Year</sup> 1943 | 9. Birthp<br>Cour<br>Penn | lace (State or Foreign)<br>Sylvania         |
| × 5 5  |                    | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town or L                                       | ocation                         |                                   |                          |  |                        | 1                         | 0d. Inside City Limit                       |
| Maryl<br>f ehc   | ē                  | Maryland Anne Art   | ınd <b>e</b> 1  |  | 3                               | Annapo                            | lis                      |  |                        |                           | 1∰Yes 2□N                                   |
| 288  | Director           | 10e. Street and Number  |   |  | 10f. Zip (                      |                                   |                          | 1  | 0g. Citizen of V       | hat Cour                  | itry?                                       |
| 3a or  |                    | 1 Names and Board   |   |  |                                 | 21401                             |                          | ī  | Jnited S               | State                     | S   |
| death<br>ms 2  | Funeral            | 1 Norwood Road  11. Marital Status  | 12. Was Decedent I<br>Armed Forces?                             | Ever in U.S. 13  |                                 |                                   | ic Origin? (Sp           | ecify Yes or No-<br>Rican, etc.)                     | 14. Race               |                           | an Indian,                                  |
| within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or items 23a or 28a-f ehow<br>ha Medical Exartinat Le Incillied at  | þ                  | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ☐ N<br>If Yes, Give X<br>Year or Dates:               | lo l   | 1 ☐ Yes 2                       |                                   |                          | Tributi, Oto.,                                       | Specify                |                           |   |
| 2 hou  | Completed          | 15. Decedent's E  | ducation  | 16a. Dec   | edent's Usual                   | Occupation                        | most of work             | una .  | 16b. Kind of Bu        | siness/In                 | dustry                                      |
| hin 7  | pje                | (Specify only highest gr<br>Elementary/Secondary (0-12)   | College (1-4or 5  | +) life.   |                                 |                                   | most of work             | 9  | 0.16 E                 | 4                         | . 1   |
| d wil  | Con                |   | 2   |  | Educ                            | ator                              |                          |  | Self En                |                           | ea  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational La notified at once.  | To Be (            | 17. Father's Name (First, Middle, Las. William P Stepher  |   |  |                                 |                                   | Mother's Name<br>Iilda S | e (First, Middle, I<br>pears                         | Maiden Sumam           | е)                        |   |
| should have  |                    | 19a. Informant's Name/Relationship  | (Type, Print)   | 19b. Mai   | ling Address                    | (Street and N                     | lumber or Run            | al Route Number                                      | , City or Town,        | State, Zip                | Code)                                       |
| alth alth 27 is  |                    | Vernon R. Tate,   | Sr./Husband   |  | lo rwood                        |                                   | Anna                     | polis, N   | Marylano               | 1 214                     | 01  |
| of He<br>of He<br>Item   |                    | 20a. Method of Disposition  | Dam aval from State   | 20b. Place of Disp<br>cemetery, cr                         | oosition (Nam<br>ematory or ott | e of<br>her place)                |                          | Date   | 20c. Location -        | City or To                | wn, State                                   |
| Page<br>lent c<br>nt: If   |                    | 1 Burial 2 □ Cremation 3 [<br>4 □ Donation 5 □ Other (Speci   |   | St. Marg   | aret's                          | Cem.                              | 12/23                    | /2005 A  | Annapol:               | is, N                     | faryland                                    |
| partition of the second of the |                    | 21. Signature of Funeral Service Lice   | nsee  |  |                                 |                                   |                          |  | -                      |                           | 1 Home, Ir                                  |
| Deparimination of the same of  |                    | 23a. Part1. Enter the disease, or con<br>shock, or heart failure. List only   | Slem  |  |                                 |                                   |                          |  |                        | lis,                      | MD 21401                                    |
| Physician / Medical Examiner  be prival-transit  per prival-transit  | cai Examiner       | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b   | a consequence of):  a consequence of):  a consequence of): |                                 | evanton                           | e)anda.                  | ICONOL INC   | 0x1c31=10              | 1                         |   |
| t the death certifica<br>by the attending ph<br>ached for use as th  | by Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal death 3  | ⊟Ectopic pre                    |                                   |                          |  | Mo                     |                           | Day Year                                    |
| tw requires that the<br>s been signed by th<br>? should be detache   |                    | Part II. Other significant conditions   | contributing to death b   | ut not resulting in the                                    | underlying ca                   | ause given in                     | Part I.                  |  |                        | ribute to ti<br>3 ☐ Prot  | ne cause of death?<br>eably 4 Unknow        |
| law<br>ast<br>2 s  | Completed          |   |   |  |                                 |                                   |                          | 24a. Was a autops                                    | SY F                   |                           | psy findings availab<br>mpletion of cause o |
| : The  |                    |   |   |  |                                 |                                   |                          |  |                        | Yes                       | 2 No  |
| ician: Th<br>certificate<br>ector, pag   | Be                 | 25. Was case referred to medical examiner?  | Hospital:   | -57-50   |                                 | Other                             |                          | h (Check only on                                     |                        |                           |   |
| Physician:<br>r this certific<br>ral director,   | 2                  | 1 Yes 2 No<br>27. Manner of Death   | 1 Inpatie   |  |                                 | A 4                               | ☐ Nursing Ho             | ome 5 Reside   |                        |                           | y)  |
| ding<br>P.<br>After<br>fune  | lon                | 1 □ Natural 5 □ Pending   | 28a. Date of Inju<br>(Month, Da)                                |  | M                               | Bc. Injury at<br>Work?<br>1 ☐ Yes | 2 € No                   | •  |                        |                           |   |
| I or Attending after death. Director: After in by the fune   | Certification;     | 2 Accident investigation 3 Suicide 6 Accould not 4 Homicide determine   | 28e. Place of Inj<br>building, et                               | ury - At home, farm, sc. (Specify)                         | street, factory,                |                                   | A U                      | nk<br>28f. Location (Si<br>City or Town<br>Annapolis | n, State) 1 No         | er or Rura                | Rd.   |
| 73   | ledical C          | (Check only 2 Medical Exa   | Physician: To the best<br>aminer: On the basis o                | f examination and/or                                       |                                 |                                   |                          | and due to the c                                     | ause(s) and ma         |                           |   |
| Hospital 24 hours 2 Funerel I  |                    | one)  | and manner sta  | 2100.  | 29c                             | . License nur                     | nber                     | 2  | 9d. Date signe         | d (Month.                 | Day, Year)                                  |
| the Hospital<br>thin 24 hours a<br>the Funerel I<br>mpletely filled  | Med                | 20h Signature and title of certifier  |   |  |                                 |                                   |                          | <b>b</b> -   |                        | 20                        | 2005  |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,  | Med                | 29b. Signature and title of certifier   | ans   |  | 0                               | .C.M.E                            |                          | be   | cember                 | 20,                       | 2005  |
| To the Hospite within 24 hours To the Funerel completely filled  | Med                | 29b. Signalare and title of certifier  20b. Signalare and title of certifier  30. Name and address of person who  | completed cause of d  |  | e, Print)                       |                                   |                          | Baltimor   |                        |                           |   |

|                |  |                   | For State Registrar   | State of M                      | faryland.                         |             | artment o                       |                  |                     | ind Me               |                                | giene                    | 15                                   | 42427  |
|----------------|--|-------------------|---|---------------------------------|-----------------------------------|-------------|---------------------------------|------------------|---------------------|----------------------|--------------------------------|--------------------------|--------------------------------------|--|
| -<br>¥         | Physici  | an                | Decedent's Name (First, Middle, Las   |                                 |                                   |             |                                 |                  |                     |                      | 2. Date of Dea                 | ath<br>Day               | a 200 5                              | 3. Time of Death                               |
|                | /Medic   |                   | Bertha Eleanon  4a. Facility Name (If not institution, give   |                                 | r)                                |             | 4b. City, Tov                   | wn, or L         | ocation of          |                      | Decem                          | 4c. Count                |                                      | 0.00   |
| 70             | Examir   | ier               | Washington County   |                                 |                                   |             | Hage                            |                  |                     |                      |                                |                          | hingt                                | on   |
| 7              | Funeral  |                   | 5. Social Security Number 6. Se   | 7. A                            | ge (In yrs. iast                  | birthday)   | If Under 1 Y                    | ear              | If Under 2<br>Hours | 24 Hrs. 8            | B. Date of Birt                | h                        | 9. Birthpl                           | lace (State or Foreign                         |
| 3              | Director   |                   | 577-42-9333   | □M 2 <b>⊠</b> F                 | 71                                | Yrs.        | Michael B                       | 4,5              | 110010              | I                    | Month, Da<br>Feb. 21           | 1934                     | Mary]                                | länd   |
|                | and *  |                   | Usual Residence of Decedent  10a. State 10b. County   |                                 | 10c. City, T                      | own or Lo   | cation                          |                  |                     | ·                    |                                |                          | 10                                   | 0d. Inside City Limits                         |
|                | Maryl<br>f sho   | ō                 | New York Saratoga   |                                 | Por                               | ter (       | Corners                         | 3                |                     |                      |                                |                          |                                      | 1 ☐Yes 2 ☑ No                                  |
|                | 288-   | Director          | 10e. Street and Number  |                                 |                                   | <u>.</u>    | 10f. Zip Co                     | de               |                     |                      |                                | 10g. Citizen of          | What Coun                            | itry?  |
|                | h with   | a D               | 370 North Green   | field Ro                        | ad                                |             | ]                               | 1285             | 9                   |                      |                                | U.S.                     | Α.                                   |  |
|                | 72 hours after death with the Maryland<br>natural', or Items 23a or 28a-f show<br>areal Examination wat be notilised at  | Funeral           | 11. Marital Status  | 12. Was Deceder<br>Armed Forces | nt Ever in U.S.                   | 13. \       | Was Decedent<br>f Yes, specify  | t of Hisp        | panic Orig          | gin? (Spec           | ify Yes or No-                 | - 14. Ra                 | ce - Americ                          |  |
| 98             | or It  | Y Fu              | 1 Never Married 2 Married   | 1 Tes 2                         | X <sup>No</sup>                   | i           | 1 Yes 2                         | 7                | Specify:            |                      |                                | Specia                   | 4                                    |  |
| 21215-0036     | hours<br>tural',   | d by              | 3 XWidowed 4 Divorced   | Year or Dates                   |                                   | Sa Dagge    | dent's Usual O                  | \aaiinatii       |                     |                      |                                |                          | WILL                                 |  |
| 15             | in 72  | Siete             | 15. Decedent's Ed<br>(Specify only highest grades)  | de completed)                   |                                   | (Give       | kind of work a<br>DO NOT use r  | tone du          | ring most           | of working           | 7                              | 16b. Kind of E           | ousiness/inc                         | dustry   |
| 212            | within<br>piane.<br>r than   | Completed         | Elementary/Secondary (0-12)   | College (1-4o                   | r 5+)                             | Own         | ner/Ope                         | erat             | or                  |                      |                                | Count                    | ry Sto                               | ore  |
|                | be filed<br>tal Hygi<br>d other<br>event, t  | BeC               | 17. Father's Name (First, Middle, Last)   |                                 |                                   |             |                                 | 1                | 8. Mother           | r's Name (           | First, Middle,                 | Maiden Sumai             | me)                                  |  |
| /lai           | should be<br>and Mental<br>marked of<br>umatic ev  | To                | George Bonhag   | ,                               |                                   |             |                                 |                  | Eli                 | zabet                | h Get                          | zendanı                  | ner                                  |  |
| Maryland       | 2 sho<br>and<br>ls m   |                   | 19a. Informant's Name/Relationship (7   | ype, Print)                     |                                   | 19b. Mailir | ng Address (Si                  | treet an         | id Number           | r or Rural           |                                | er, City or Town         |                                      |  |
|                | ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiane. If Item 27 is marked other than "natural", or Items 23a or 28a-1 show or other treumatic event, the Marical Examiner Frust be nutilised at |                   | Jeffrey B. Schwar<br>20a. Method of Disposition   | tzbeck -                        |                                   |             | Meado                           |                  | rk D                | rive,                |                                | nsville ;                |                                      | land 21754                                     |
| Jor            | Pages 1<br>nent of H<br>int: If Ite  |                   | 1 ☐ Burial 2 🖫 Cremation 3 ☐  |                                 | e cem                             | etery, cren | natory or othe                  | r place)         | - 1                 |                      |                                |                          | •                                    |  |
| Baltimore,     | 를 된 <b>된 글</b> .   |                   | 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen                                      | -                               | Metr                              |             |                                 |                  |                     |                      |                                |                          |                                      | a, Virginia                                    |
| Ba             | Depa<br>Depa<br>Impo<br>any i  |                   | Novert L  | Wil                             | liam                              |             |                                 |                  |                     |                      |                                | Funeral                  |                                      |  |
| · 65           | -  |                   | 23a. Part1. Enter the disease, or comp  | lications that caus             | ed the death. I                   | Do not ent  | er the mode of                  | Lage<br>f dying, | such as o           | d , Da<br>cardiac or | mascus<br>respiratory ar       | mary]                    | Land                                 | 20872<br>Approximate                           |
|                | Physician<br>/Medical  |                   | shock, or heart failure. List only of<br>Immediate Cause (Final   | ne cause on each                | e oxi                             | 0 00-       | Van le                          | 10.              | · · · ()            | ) .                  | Art                            | 20                       |                                      | Interval Between<br>Onset and Death            |
|                | /Medical   |                   | disease or condition resulting in death)  | a. Due to (or a                 | as a consequen                    | ice of):    | I OR C                          |                  | لاعال               | 4                    | That I                         | 100                      |                                      |  |
| *              | Examiner   |                   | Sequentially list conditions  | ner.                            | Julik                             | 2 fc        | rele                            | ere              | , 6                 | ace                  | ite                            |                          |                                      |  |
| -              | P #  | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or a                    | is a consequen                    | ice of):    |                                 |                  | ,                   |                      |                                |                          |                                      |  |
|                | and<br>and<br>I-tran   | Examiner          | that initiated events resulting in death) Last  | c. Due to (or a                 | S a consequen                     | (ce of):    |                                 |                  |                     |                      |                                |                          |                                      |  |
| 8760,          | cate be executed<br>physicien and<br>the burial-transit  |                   |   | Re                              | enal                              | I.          | 0, 6                            |                  | ,                   |                      |                                |                          |                                      |  |
| 687            | ficate<br>p phys   | Physician/Medicai |   | d                               |                                   |             |                                 | 1                |                     |                      |                                |                          |                                      |  |
| Вох            | death certific<br>e attending p<br>d for use as I  | n/M               | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcom             | ne of pregnancy<br>2  Fetal de    |             | ) <del>_</del>                  |                  |                     |                      |                                | 23d. Da                  | ate of delive                        | ry   |
|                |  | icia              | in the past 12 months?  | _                               | at time of death                  |             | JEctopic pregr<br>Other (specil |                  |                     |                      |                                | M                        | onth                                 | Day Year                                       |
| P.O.           | that the de<br>led by the a<br>detached t  | hys               | 9 □ Unknown   |                                 |                                   |             |                                 |                  |                     |                      |                                |                          |                                      |  |
|                | Se 55 9  | by                | Part II. Dther significant conditions co  | ontributing to death            | but not resulting                 | ng in the u | nderlying caus                  | e given          | in Part I.          |                      |                                | /                        |                                      | e cause of death?                              |
| ord            | w requir<br>been si<br>should  | ted               | Jean C ben h  | unu c                           | un Co                             | da          | au !                            | sec              | e contraction       |                      | 10                             | es 2 No                  | 3 [] P1004                           | ably 4 □Unknown                                |
| 3ec            | has b  | Completed         |   |                                 |                                   |             |                                 |                  |                     |                      | 24a. Was<br>autop              |                          | Were autor<br>prior to con<br>death? | osy findings available<br>npletion of cause of |
| Vital Records, |  |                   |   |                                 |                                   |             |                                 |                  |                     |                      | 1 Yes                          | 2 <b>\tag{\text{No}}</b> |                                      | 2 No   |
| Ξ              | Physician:<br>r this certific<br>ral director,   | o Be              | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital: 1 Clipa               | tiont 2DED                        | /Outpatien  | t 3 DOA                         |                  |                     |                      | Check only o                   | ne)<br>dence 6 □Oti      | (C 4                                 |  |
| o              | g Phys<br>er this<br>eral di   | n: To             | 27. Manner of Death   | 28a. Date of In                 | iury 28                           | b. Time of  |                                 | Injury a         | at                  |                      |                                | now injury occur         |                                      | 7  |
| ion            | Attending F<br>r death.<br>ector: After<br>by the funer  | atio              | 1 ♣ Natural 5 Pending 2 Accident investigation  | (Month, E                       | Jay ( ear)                        | Injury      | м                               | Work?<br>1 ☐ Ye  | es 2 🗆 N            | No                   |                                |                          |                                      |  |
| Division       | l or Attendation after death<br>Director:  | Certification:    | 3 Suicide 6 Could not be<br>4 Homicide determined   | 289. Place of I                 | njury - At home<br>etc. (Specify) | , farm, str | eet, factory, of                | ffice            |                     | 28                   | 3f. Location (S<br>City or Tow | Street and Numi          | ber or Rura                          | Route Number,                                  |
|                | vital or<br>urs afte<br>rel Dire   |                   |   |                                 |                                   |             |                                 |                  |                     |                      |                                |                          |                                      |  |
|                | To the Hospital or Attanding Physician: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.   | edical            | 29a. Certifier 1 Certifying Phy<br>(Check only 2 Medical Examone)   |                                 | of examination                    |             |                                 |                  |                     |                      |                                |                          |                                      |  |
|                | othe<br>othe<br>omple  | Med               | 29b. Signature and title of certifier   | and manner                      | stated.                           |             | 29c. Li                         | icense r         | number              |                      |                                | 29d. Date signe          | ed (Month, L                         | Day, Year)                                     |
|                | - 5 - 0  | 2                 | 1 m   | عس                              | no                                |             | D                               | 6                | 25                  | 8 8                  | 3                              | 121                      | 16/0                                 | 005  |
|                | \ <u>\</u>   |                   | 30. Name and address of person who d  | completed cause of              | f death (Item 23                  | Ва) (Туре,  | Print)                          |                  |                     |                      |                                | 1                        | 12                                   |  |
|                | 10   | -                 | 151 Ruer ar   | hetar                           | n 8h                              | eet         | Here                            | 9.5              | stoc                | NA                   | חם מ                           | 2174                     | 6                                    |  |
|                | Sta  |                   | 31. Date filed (Month, Day DEC 1  | 9 2005 Regis                    | str s Signature                   | ۹           |                                 |                  |                     | /                    |                                |                          |                                      |  |
| 1              | Registi  | aľ                |   |                                 |                                   | S.          | Book                            | 2                |                     |                      |                                |                          |                                      |  |

|                    |  |  | 1 - For<br>State<br>Registrar   | State  | of Maryland                               |  | artment of F<br>rtificate of                                    |   | nd Mental Hy                             | 10   | 000  | 1,21,28  |  |
|--------------------|--|--|---|--|---|--|---|---|--|--|--|--|--|
|                    |  |  | Decedent's Name (First, Middle  | 2. Date  |   |  | Reg. No. UU 3 4 4 4 6 0 of Death 3. Time of Death               |   |  |  |  |  |  |
|                    | Physici<br>/Media  |  | RICHARD LEE TURNER SR.  |  |   |  |   |   | Month<br>DECEMI                          | BER 1  |  | 7:54 A M   |  |
|                    | Examir   |  | 4a. Facility Name (If not institution, give street and number)  |  |   |  | 4b. City, Town, o   | r Location of [   |  |  | County of Death                                | 7:54 A   |  |
|                    |  |  | 12519 HUYETT'S LANE   |  |   |  | HAGERSTOWN  |   |  | WASHINGTON   |  |  |  |
|                    | Funeral  |  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   |  |   | If Under 1 Year   If Under 24 Hrs.   8. Date |   |   | of Birth                                 |  |  |  |  |
| aryland 21215-0036 | Director   |  | 220-42-5543 <sup>1XI M 2   F</sup> 61 Yrs.  |  |   | Months Days Hours Min. (Month                |   |   | 29, 1944 MARYLAND                        |  |  |  |  |
|                    | pur *  |  | Usual Residence of Decedent  10a. State 10b. County   |  | 10c City                                  | Tourn ord o                                  |   |   |  |  |  |  |  |
|                    | sho  | Funeral Director   | Tod. Inside City Limits   |  |   |  |   |   |  |  |  |  |  |
|                    | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Itams 23e or 28a-f show<br>ha Madical Evanirer must be notified at   |  | MARYLAND WASH   | HAGERSTOWN  10f. Zip Code                      |   |  |   |   | 1 ☐ Yes 2 X No                           |  |  |  |  |
|                    |  |  | 12519 HUYETT'S  | 21740  |   |  | 10g. Citi   | zen of What Coun  | •  |  |  |  |  |
|                    |  | era  | 11. Marital Status  |  | edent Ever in U.S.                        | 13 \   |   |   |  |  | U.S.A  |  |  |
|                    |  | 들  |   | 1 □ Never Married 2 □ Married   1 ☒ Yes 2 □ No |   |  |   | Was Decedent of Hispanic Origin? (Specify Yes or No<br>f Yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |  | Black, White, etc.                             |  |  |
|                    | al', o   | ğ  | 3 🗆 Widowed 4 🖾 Divorced  | Yes 2X No Specify:                             |   |  |   | Specify: WHITE  |  |  |  |  |  |
|                    | <ol> <li>Pages 1 and 2 should be filed<br/>rtment of Health and Mental Hygi<br/>rtant: If item 27 is marked other<br/>njury or other traumatic event.</li> </ol>   | ted  | 15. Deceden   | t's Education                                  |   | 16a. Deced                                   | dent's Usual Occup  | ation   |  | 16b. Ki  | nd of Business/Ind                             |  |  |
|                    |  | Completed by   | Elementary/Secondary (0-12) College (1-4or 5+)  |  |   |  | kind of work done during most of working<br>DO NOT use retired) |   |  |  |  |  |  |
|                    |  | Co   | 12  |  |   |  | TRUCK DRI   | VER   |  | TR   | UCKING CO                                      | OMPANY   |  |
|                    |  | To Be  | 17. Father's Name (First, Middle,   | Last)  |   |  |   |   | Name (First, Middle                      |  | Sumame)  |  |  |
| <u>Ş</u>           |  |  | WILMER TURNER LOIS MARIE KECKLER  |  |   |  |   |   |  |  |  |  |  |
| Na                 |  |  | 19a. Informant's Name/Relations   |  |   |  |   |   | or Rural Route Numb                      |  |  | •  |  |
| ė,                 |  |  | GINGER GRIMM/P 20a. Method of Disposition   | ERSUNAL R                                      |   |  | O LEUN GF<br>sition (Name of                                    | CTMM DR   | Date HAGE                                |  |  | LAND 21740                                       |  |
| more,              |  |  | 1 X Burial 2 ☐ Cremation  |  | State cem                                 | etery, cren                                  | natory or other plac  | .   |  |  | cation - City or Tov                           |  |  |
| altir              |  |  | ' 4 □ Donation 5 □ Other (S   |  | BOOM                                      |  | CEMETER  . Name and Addres                                      |   | /21/2005                                 |  | NSBORO, M                                      |  |  |
| B                  | Depa<br>Depa<br>Impo<br>any ii   |  | De la la la la la la la la la la la la la   |  | ul M. Dea                                 | $\mathbf{n} \mid \mathbf{B} \mathbf{A}$      | AST FUNER   | AL HOM  |  |  | ational F                                      |  |  |
|                    | Physician<br>/Medical  |  | 23a. Part I. Enter the disease, or  | complications that of                          | aused the death.                          | Do not ente                                  | er the mode of dying  | g, such as car  | rdiac or respiratory a                   | rrest.   | Maryland                                       | L 21713<br>Approximate                           |  |
| l                  |  |  | Immediate Cause (Final  A  Interval Between Onset and Death   |  |   |  |   |   |  |  |  |  |  |
|                    |  | lner   | disease or condition resulting in death)  a. Acut myo Cardy Duption (or as a consequence of):   |  |   |  |   |   |  |  | to min   |  |  |
|                    | Examiner   |  | Sequentially list conditions, b. Anterio School Cardio Varante  |  |   |  |   |   |  | uer.   |  | Zus  |  |
|                    | sit ad   |  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   |  |   |  |   |   |  |  |  |  |  |
|                    | and<br>I-tran  | The production of the producti |   |  |   |  |   |   |  |  |  |  |  |
| 9                  | ficate be executed<br>physician and<br>is the burial-transit   |  | bue to (or as a consequence or).  |  |   |  |   |   |  |  |  |  |  |
| 09/89              |  | edicai   |   | d  |   |  |   |   |  |  |  |  |  |
| Rox                | eath certifi<br>attending<br>for use as  | n/Me   | IF FEMALE:<br>23b. Was decedent pregnant  |  | come of pregnancy                         |  |   |   |  | 2  | 3d. Date of deliver                            |  |  |
|                    | 000  | Icla   | in the past 12 months?  | 4 ☐ Pregr                                      | oirth 2 Fetal de<br>nant at time of deatl |  | Ectopic pregnancy<br>Other (specify)                            |   |  | -  |  | y<br>Day Year                                    |  |
| J.                 |  | by Physician/M   | 9 Unknown   | 9□ Unkn  | own                                       |  |   |   |  |  |  |  |  |
|                    | as the control of the |  | Part II. Other significant condition  | ns contributing to d                           | eath but not resultin                     | ng in the un                                 | derlying cause give   | n in Part I.  | 23e. Did t                               | obacco us  | se contribute to the                           | cause of death?                                  |  |
| ecords,            | w require<br>been sig  |  | chanic of milita Pulman Direce  |  |   |  |   |   | _ 10,                                    | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown                            |  |  |  |
| ပ္သ                | y CS S   | on: To Be Completed  | Carcicone Protet  |  |   |  |   |   |  | 24a. Was an 24b. Were a  |  | utopsy findings available completion of cause of |  |
| T,                 | The<br>ate ha  |  |   |  |   |  |   |   | — autop<br>perfo<br>1 ☐ Yes              | osy<br>rmed?<br>2 1 No   | prior to com<br>death?<br>1 \( \text{Yes} \) 2 |  |  |
| n or vital         | hysician<br>his certifi<br>I director  |  | 25. Was case referred to medical examiner?  |  |   |  |   | 26. Place of I  | Death (Check only o                      |  | 103 2  |  |  |
|                    |  |  | 1 ☐ Yes 2 ☑ No  | 3□ DOA Othe                                    | r: 4 🗆 Nursin                             | ng Home 5 THesia                             | Residence 6 □Other (Specify)                                    |   |  |  |  |  |  |
|                    | th.<br>Th.<br>Tunera   |  | 27. Manner of Death 28a. Date of Injury 1 Natural 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28b. Time of 28c. Injury at Work? |  |   |  |   |   |  |  |  |  |  |
| Vision             | tend<br>death<br>tor: /  | cat  | 2 Accident investig   |  | es 2 □ No                                 |  |   |   |  |  |  |  |  |
| 5                  | or A   | Certification:   | 4 Homicide  4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, stree building, etc. (Specify)  |  |   |  |   |   | 28f. Location (S<br>City or Tox          | ntion (Street and Number or Rural Route Number,<br>or Town, State) |  |  |  |
| _                  | spital<br>ours<br>ours<br>illed  |  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the course's and           |  |   |  |   |   |  |  |  |  |  |
|                    | To the Hospital or Attending P<br>within 24 hours after death.<br>To the Funerel Director: After It<br>completely filled in by the funera  | edical   | (Check only 2 Medical E   | xaminer: On the ba                             | asis of examination<br>ner stated.        | and/or inve                                  | estigation, in my op  | nion, death o   | ace, and due to the courred at the time, | date and p   | olace, and due to t                            | he cause(s)                                      |  |
|                    | = 글 = 글  | Me   | 29b. Signature and title of certifier 29c. License number   |  |   |  |   |   |  | 29d. Date signed (Month, Day, Year)                                |  |  |  |
|                    | 5 1 × 5 5  |  | D 18019   |  |   |  |   |   |  | DEC. 192005  |  |  |  |
|                    | To Vit   |  | - the   |  |   |  | 0 (4  | 0 (7  |  | 1766   | 192  | 200  |  |
|                    |  |  | 30. Name and address of person v  | vho completed caus                             | e of death (Item 23                       |  | rint)   |   |  |  |  | _  |  |
|                    | 우호우 호<br>나사<br>Stat  |  | 30. Name and address of person v  | who completed caus                             | e of death (Item 23                       |  | rint)   |   | 70 W N                                   | M  |  | _  |  |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene) For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2,2005 Month Vernon **Physician** Τ. Thomas 12:05PM December /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital 8. Date of Birth Month, Day, Year) Apr. 6, 1942 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours Kentucky 11√2 M 2□ F 63 578-54-1510 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Marylenc 10a. State 10b. County or Itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Takoma Park Montgomery by Funeral Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20912 USA #509 7051 Carroll Ave. deeth 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or Ital 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: Black 3 ☐ Widowed 4 N Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Record Promoter Promoting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Thomas Annabe11 Elsworth ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peges 1 end 2 s ment of Health an 22078 Foxglove Place Great Mills, MD20634 Margo Gross/Daughter them 27 i 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Peges
Department of importent: if it any injury or o Chelt. Vet. Cem. 12/12/05 Cheltenham, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sewell Funeral Home 451 Dares Beach Rd. Prince Fred., MD20678 21. Signature of Funeral Service Licenses Gladys 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Energiou Asculta **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed JU13 5571 for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No should be detached Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has 1 ☐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural after death.

Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a ←⊒\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Azu en, nu MERON 31. Date filed (Month, Day, Year) 32. Registrar's Signature State - 7 2005 Course Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FRANCES SMITH TURNER NOVEMBER 28, 2005 6:48 A. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MALCOLM GROW MEDICAL CENTER PRINCE GEORGE'S CAMP SPRINGS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/17/33 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M XXF Days Hours VIRGINIA 72 Yrs 231-40-0051 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ?7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Modical Examinar must be notified at MD PRINCE GEORGE'S TEMPLE HILLS XX Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20748 2008 COLEBROOK DRIVE USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. be filed within 72 hours after di tal Hygiene. d other than "natural", or item Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 2 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) NATIONAL LABOR College (1-4or 5+) Elementary/Secondary (0-12) RELATIONS BOARD FILE CLERK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 is marked other any lightly or other treumatic event 2008. ISADORA SEARS ARNOLD SMITH, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEMPLE HILLS, MD 20748 2008 COLEBROOK DR. FRANCES HAWKINS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON NATIONAL 12/09/05 ARLINGTON, VA <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME 21. Signature of Funeral Service Licens 14308 SUITLAND RD. SUITLAND, MD 20748 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONARY EMBOLISM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner THROMBOEMBOLISM Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit IMMOBILITY ASSOCIATED WITH ALZHEIMERS attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year jo in the past 12 months? Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform 1 Yes 1 Yes 2X No Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Dther. 1 🗌 Yes 2 / XNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his 28b. Time of Injury 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending 1 Tes 2 🗌 No 24 hours after death. Funerei Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2  $\infty$ 0102201393- VA 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHN B. SHEHAN, CPT, USA, MC 1050 W. PERIMETER RD ANDREWS AFB, MD 20762 . Registrar's Signature State 2005 Registrar

THOMAS

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month
DECEMBER 9, 2005 **Physician** MICHAEL MATTHEW VANDLING 2:50 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 1**™**M 2□ F Director Yrs 4 AUG. 7,2005 MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD **QUEEN ANNES** CENTREVILLE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 125 COMET DRIVE 21617 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian other treumetic event, the Medical Exertiner Pages 1 and 2 should be filed within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 X No Completed by 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Be UNKNOWN MICHELE VANDLING 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. CARIN SHAKLEE/ SOCIAL WORKER 125 COMET DRIVE, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State STEVENSVILLE CEMETERY 12-14, 2005 STEVENSVILLE, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic see 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 engler 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -espirata disease or condition resulting in death) /Medical Examiner Sequentially list or Titlers if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitat or Attending Physician: The law requires that the death certificate be executed burial-transit nct N attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 🗙 No 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 \( \square\) No 1 X Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? After 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a a Funaraí I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OVY D0061011 12-14-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South recene St. ATISM FORCK MD Univ of MARYLAND BAITIMORE, M& 21201 32. egistrar's Signature State Registrar

|             |  | ı                   | For<br>State<br>Registrar   | State of Marylan  |                 | artment of<br>rtificate of                            |                     | d Mental Hy                        | giene<br>Reg. No.              | 15   | 42433   |
|-------------|--|---------------------|---|---|-----------------|---|---------------------|------------------------------------|--------------------------------|--|---|
|             | Physici  |                     | 1. Decedent's Name (First, Middle, Las  | Valentin  | •               |   |                     | 2. Date of De<br>Month             |                                | ()S  | 3. Time of Death                                    |
|             | /Medic<br>Examin   | -                   | 4a. Facility Name (If not institution, give Anne Anne Social Security Number 6. S   | Medical Cer   | last birthday)  | 4b. City, Town,                                       | or Location of De   | eath                               | 4c. Count                      | y of Death                                   | rudel<br>lace (State or Foreign                     |
| ¥**         | Funeral<br>Director  |                     |   | □м <b>Ж</b> Х 77  | Yrs.            | Months Days   |                     | lin. (Month, Da                    | ay, Year)<br>9, 1928           | Coun   | ington, DC  |
|             | /land  |                     | 10a. State 10b. County  | 10c. Cit  | y, Town or Lo   | cation  |                     |                                    |                                | 1  | 0d. Inside City Limits                              |
|             | e Mar  | ctor                | MD Anne Ar  | undel Edg   | gewater         |   |                     |                                    |                                |  | 1 ☐ Yes 2 📉 No                                      |
|             | or 28  | Dire                | 10e. Street and Number  |   |                 | 10f. Zip Code   | _                   |                                    | 10g. Citizen of                | What Coun                                    | itry?   |
|             | 9ath v   | eral                | 3726 Beach Drive  | BLvd •  12. Was Decedent Ever in U.   | S 13            | 210:  |                     | (Specify Yes or No                 | USA<br>3- 14. Re               | ice - Americ                                 | an Indian.  |
| 21215-0036  | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ※ Widowed 4 ☐ Divorced  | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:                                      |                 | f Yes, sp <i>ec</i> ify Cu<br>1 ☐ Yes 2 <b>X</b> ) No | ban, Mexican, Pi    | uerto Rican, etc.)                 |                                | ack, White,                                  |   |
| 5-0         | 72 ho<br>'natur  | Completed           | 15. Decedent's E  | ducation<br>de completed)   | (Give           | dent's Usual Occu<br>kind of work done                | during most of      | working                            | 16b. Kind of I                 | 3usiness/Ind                                 | lustry  |
| 121         | within 72<br>ene.<br>than "net   | ldm                 | Elementary/Secondary (0-12)   | College (1-4or 5+)  | Secre           | DO NOT use retir                                      | 9d)                 |                                    | Law                            |  |   |
|             | filed withi<br>Hygiene.<br>other than  |                     | 17. Father's Name (First, Middle, Last  | )   | Decre           | cary  | 18. Mother's        | Name (First, Middle                |                                | me)  |   |
| lan         | Mental Mental arked o  | To Be               | William Guilbert  |   |                 |   | Mary                | Shelton                            |                                |  |   |
| Maryland    | 2 should<br>and Men<br>is marke  | -                   | 19a. Informant's Name/Relationship (  | Type, Print)  | 19b. Maili      | ng Address (Stree                                     | at and Number or    | Rural Route Numb                   | er, City or Town               | , State, Zip                                 | Code)   |
|             | s 1 and 2<br>of Health<br>Item 27 i  |                     | Deborah A. Gates  |   |                 | Beach I   | Orive B1            | vd., Edge                          | water,                         |  |   |
| Baltimore,  | Pages 1<br>nent of H<br>int: if Ite  |                     | 20a. Method of Disposition<br>1 ☐ Burial 2 X Cremation 3 ☐  | Removal from State  | emetery, cre    | natory or other pl                                    |                     |                                    |                                | •  |   |
| Ħ           |  |                     | 4 □Donation 5 □Other (Special 21. Signature of Funeral Service Lice   |   |                 | matory  2. Name and Add                               |                     | -13-2005                           | Baltim                         | ore,   | MD  |
| Ba          | permit. Departr Imports any Inje   |                     | 13- 2.0   | <u></u>   |                 | Hardest<br>12 Ridg                                    | y Funér<br>gely Ave | al Home,<br>nue, Anna              | polis,                         | MD 21  |   |
|             | Physician  |                     | 23a. Part1. Enter the disease, or com-<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. Presmo   | nia             | er the mode of ay                                     | ring, such as care  | glac or respiratory a              | irrest,                        |  | Approximate<br>Interval Between<br>Conset and Death |
|             | /Medical<br>Examiner   |                     | 1   | Due to (or as a conseq  | uence of):      |   |                     |                                    |                                |  | 0000  |
| 6).         |  | Jer                 | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a conseq   | uence of):      |   |                     |                                    |                                |  | yeus.   |
|             | cuted<br>nd<br>ransit  | Examiner            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | C   |                 |   |                     |                                    |                                |  |   |
| 90,         | cate be executed<br>obysicien and<br>the burial-transit  | Ex                  | resulting in death) Last  | Due to (or as a conseq  | uence of):      |   |                     |                                    |                                |  |   |
| 8760,       | cate b<br>physic<br>the b  | dlcal               |   | d   |                 |   |                     |                                    |                                |  |   |
| O. Box 6    | requires that the death certificate be executed<br>een signed by the attending physicien and<br>nouid be detached for use as the burial-transit  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1  Yes 2 No 9 Unknown  | 23c. If yes, outcome of pregna<br>1□Live birth 2□Feta<br>4□Pregnant at time of d<br>9□Unknown | Ideath 3        | Ectopic pregnan Other (specify)                       |                     |                                    | 1                              | ate of delive<br>lonth                       | ery<br>Day Year                                     |
| <u> </u>    | res that tigned by   |                     | Part II. Other significant conditions   | contributing to death but not res   | ulting in the u | nderlying cause g                                     | iven in Part I.     |                                    | tobacco use cor                |  | ne cause of death?                                  |
| ord         | v require<br>been sig<br>should b  | eted                |   |   |                 |   |                     | -                                  |                                |  |   |
| al Records, | The lay  | Completed by        |   |   |                 |   |                     | 1 ☐ Yes                            | ormed?<br>2 No                 | prior to coi<br>death?<br>1 \( \text{Yes} \) | psy findings available mpletion of cause of         |
| Vital       | Physician:<br>this certific<br>ral director,   | o Be                | 25. Was case referred to predical examiner?  1  Yes 2 No  | Hospital: 1 Inpatient 2   | ER/Outpatie     | nt 3 DOA  | thor                | Death (Check only  ig Home 5 ☐ Res |                                | har (Cogoif                                  | ···   |
| οι          | ig Phys<br>ter this<br>heral di  | n: To               | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time o     | f 28c. Inj  |                     |                                    | how injury occu                |  | <u></u>   |
| sior        | Attending<br>r death.<br>ector: After  | atlo                | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be   | n   |                 |   | ☐Yes 2☐No           |                                    |                                |  |   |
| Division of | al or Att  | Certification:      | 3 Suicide 6 Could not be determined   |   |                 | reet, factory, office                                 | Э                   | 28f. Location (<br>City or To      | (Street and Num<br>own, State) | ber or Rura                                  | al Route Number,                                    |
|             | To the Hospital or Attending F within 24 hours after death. To the Funers! Director: After completely filled in by the funer.  | Medical (           |   | hysician: To the best of my knominer: On the basis of examination                             |                 |   |                     |                                    |                                |  |   |
|             | within 2<br>To the   | Me                  | 29b. Signature and title of continer  | ///   |                 | 29c. Lice   | nse number          |                                    | 29d. Date sign                 | ed (Month,                                   | Day, Year)  |
|             |  |                     | 1///  | lu  |                 | DS  | 5892                | 7                                  | 12/11                          | 105  |   |
|             |  |                     | 30. Name and agreess of person who  | completed cause of death (Item 200)   | n 23a) (Type    | Print)  | Ann                 | polis. V                           | up 1                           | 2140   | <b>)</b> (  |
|             | Sta<br>Regist  |                     | 31. Date filed (Month, Day, Year) DEC 1 4   | 32. registrar's Signa   | ature A         | hoofs 8   |                     |                                    |                                |  |   |

|             |  |                       | _   | State of M  | larvlan                                | d / Depa   | artment d                                   | of Hea   | alth and              | Mental Hy                          | aiene                            | may gong grow                                 | 10101   |
|-------------|--|-----------------------|---|---|--|--|---|--|-----------------------|------------------------------------|----------------------------------|---|---|
|             |  | •                     | For<br>State<br>Registrar   |   | y (                                    |  | tificate                                    |  |                       |                                    | Reg. No                          | HUD   | 42434   |
|             | Dhaminia   |                       | 1. Decedent's Name (First, Middle, L  | ast)  |  |  | -   |  |                       | 2. Date of De                      |                                  |   | 3. Time of Death  |
|             | Physicia<br>/Medic   | al                    | Rita Carmen W   |   |  |  |   |  |                       | Decemb                             |                                  | 10, 200                                       |   |
|             | Examin   | er                    | 4a. Facility Name (If not institution, g  |   | )                                      |  | 4b. City, Tov                               |  | cation of De          | ath                                | 40.                              | Carro   |   |
|             | Funeral  |                       | Lorien - Mt. Ai  5. Social Security Number 6.   | Sex 7. A  | ge (In yrs. I                          | ast birthday)  | Mt. A<br>If Under 1 Y<br>Months D           | ear If   | Under 24 H            |                                    | rth                              |   | Birthplace (State or Foreign<br>Country)                |
| н           | Director   |                       | 434-26-9353   | 1□M 2 <b>-</b> F  | 87                                     | Yrs.   | Months                                      | ays  | iouis Mi              | Nov 8                              |                                  |   | Duisiana  |
|             | land<br>Dw   |                       | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City                              | , Town or Lo   | cation                                      |  |                       |                                    |                                  |   | 10d. Inside City Limits                                 |
|             | Mary<br>a-f sh   | tor                   | Maryland Carr   | oll   |  | Westm  | unster                                      |  |                       |                                    |                                  |   | 1 Yes 2 □ No  |
|             | or 284   | Director              | 10e. Street and Number  |   |  |  | 10f. Zip Co                                 | ode  |                       |                                    | 10g. Cit                         | izen of What                                  | Country?  |
|             | s 23e  |                       | 48 Timber Ridge   |   | Complete the                           | 0 40.1   | Man Donados                                 | 211  |                       | Spacify Voc or N                   |                                  | JSA   | merican Indian.   |
|             | ter de   | Funeral               | <ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>  | 12. Was Decedent<br>Armed Forces<br>1 ☐ Yes 2 ☐   | ?                                      |  |   |  |                       | (Specify Yes or Nerto Rican, etc.) | ,                                | Black, W                                      |   |
| 036         | el', or  | þ                     | 3 ☑ Widowed 4 □ Divorced  | If Yes, Give Year or Dates:   | -                                      |  | 1□Yes 2🔯                                    | No S   | pecify:               |                                    |                                  | Specify:                                      | Mhite   |
| 21215-0036  | filed within 72 hours after death with the Maryland<br>Hygiene.<br>sther then "naturel", or Items 23e or 28e-f show<br>ant, the Madical Examiner must be notified at | Completed             | 15. Decedent's<br>(Specify only highest g   | Education<br>grade completed)   |  | (Give  | dent's Usual C<br>kind of work of           | tone durin   | n<br>ng most of w     | orking                             | 16b. K                           | ind of Busines                                | ss/Industry   |
| 121         | within<br>ene.<br>than   | Jup                   | Elementary/Secondary (0-12)   | College (1-4or  | 5+)                                    |  | <i>DO NOT</i> use <i>r</i><br><b>Memake</b> |  |                       |                                    |                                  | Own Ho  | ome   |
| 1d 2        |  | Be Co                 | 17. Father's Name (First, Middle, Las   |   |  |  |   | 18.  | . Mother's N          | ame (First, Middle                 | , Maider                         | Sumame)                                       |   |
| /lar        | 2 should be filed<br>and Mental Hygi<br>is marked other<br>sumatic event,  | To B                  | Yves LeBlanc  |   |  |  |   |  |                       | ctoria Or                          |                                  |   |   |
| Maryland    | a sa   |                       | 19a. Informant's Name/Relationship  |   | Com                                    |  | _   |  |                       | Rural Route Numb                   |                                  |   | a, Zip Coda)  |
|             | s 1 and 2<br>if Health<br>Item 27<br>other tre   | 1                     | John R. Warehime 20a. Method of Disposition   | <u> </u>  | Son<br>20b. P                          | lace of Dispo  | ond St.                                     | of   | SUILLI                | Ster, MD                           |                                  | L157<br>ocation - City                        | or Town, State  |
| nor         | ages<br>ant of<br>nt: ff lt<br>y or o  |                       | 1 ☐ Burial 2 【Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec   |   | 9                                      |  | natory or othe                              |  | nd 11                 | 2/12/05                            | Ham                              | Stead   | Maryland  |
| Baltimore,  | permit. Pages Department of I Importent: If Ite any injury or of   |                       | 21. Sign ture of Funeral Service Lic  |   | Car                                    |  |   |  |                       |                                    |                                  |   | Chapel, PA  |
| 8           | Deparmi<br>Deparmi<br>Impo<br>any ir   |                       | July K M  |   |  | 41   | .2 Wash                                     | ingt   | on Rd                 | . Westmir                          | nstei                            |   | 21157   |
|             |  |                       | 23a. Part . Enter the disease, or co<br>shock, or heart failure. List on  | ly one cause on each  | line.                                  |  |   |  |                       |                                    |                                  |   | Approximate<br>Interval Between<br>Onset and Death      |
|             | Physician<br>/Medical  | 4                     | Immediate Cause (Final disease or condition resulting in death)   | a. End St   |  |  | Cirrh                                       | osis   | (Non                  | Alcohol                            | lc)                              |   | years   |
|             | Examiner   |                       |   | <sub>b.</sub> Failur  |  |  | 2   |  |                       |                                    |                                  |   | months  |
|             | р <u>;</u>   | ner                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or a  |  |  |   |  |                       |                                    |                                  |   |   |
|             | be executed<br>sician and<br>burial-transit  | Examiner              | that initiated events resulting in death) Last  | c. Hypert   |  |  |   |  |                       |                                    |                                  |   | years   |
| 760,        | te be e:<br>ysician<br>ie buria  | calE                  |   | Trifas  | cicul                                  | ar Blo   | ck Arr                                      | ythm   | ia                    |                                    |                                  |   | 1 year  |
| 68          | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit   |                       | IE EENALE.  |   |  |  |   |  |                       |                                    | 1                                |   |   |
| Вох         | ath cer<br>tendir<br>or use  | Physician/Med         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcom<br>1 Live birth   | 2 🗌 Feta                               | Ideath 3□  | Ectopic pregi                               |  |                       |                                    |                                  | 23d. Date of o                                | delivery<br>Day Year                                    |
| 0.          | the a  | yslc                  | 1 ☐ Yes 2 No<br>9 ☐ Unknown   | 4∏Pregnant a<br>9☐ Unknown  | at time of d                           | eath 5∟  | Other (speci                                | rfy)   |                       |                                    |                                  |   | ,   |
| Ω.          | that the de<br>ned by the a<br>detached f  | y Ph                  | Part II. Other significant conditions   | s contributing to death   | but not res                            | ulting in the u  | nderlying caus                              | se given ir  | n Part I.             | 23e. Did                           | tobacco                          | use contribute                                | to the cause of death?                                  |
| Records,    | w requires<br>been sign<br>should be   | ed by                 | Depression Hypo   | albumin   |  |  |   |  |                       | 1 🗆                                | Yes 2                            | <b>X</b> No 3□                                | Probably 4 Unknown                                      |
| eco         | law reas bee   | Completed             | Anemia s/p  | pneumonia   | s                                      |  |   |  |                       | 24a. Wa:                           | posy                             | prior 1                                       | autopsy findings available<br>to completion of cause of |
| E E         |  | Com                   |   |   |  |  |   |  |                       | perf<br>1 ☐ Yes                    | ormed?                           | death<br>1 🗆 Y                                | i?<br>′es 2 <b>∑</b> No                                 |
| Vital       | Physiclen: The law<br>this certificate has b<br>ral director, page 2 s   | o Be                  | 25. Was case referred to medical examiner?  | Hospital:   |  | FB/0-4   | nt 3 DOA                                    | Othor  |                       | eath (Check only<br>Home 5 Res     |                                  | C Cother (C                                   |   |
| of          | Phy<br>r this<br>ral d   | -                     | 1 Yes 2 No 27. Manner of Death  | 28a. Date of In<br>(Month, D  |  | 28b. Time o  |   | Injury at Work?  |                       | 28d. Describe                      |                                  | -   | рөспу)  |
| Division    | 2 4 ⊆  | 0                     | 1XXX atural 5 ☐ Pending<br>2 ☐ Accident investigat  |   | ay rear                                | Injury   | М   |  | 2 🗆 No                |                                    |                                  |   |   |
| .07         | andi.<br>sath.<br>or: A<br>he fu   | atic                  | 2 Di Hoordonii  |   |  |  |   |  |                       | OOF Location                       | (Street a)                       | nd Number or                                  | Rural Route Number,                                     |
| <u>&gt;</u> | deatl<br>ctor:<br>/ the  | rtification           | 2   Accident   Restigation   3   Suicide   6   Could not determine  | t be 28e. Place of li   | njury - At ho<br>etc. <i>(Specif</i>   | ome, farm, sti<br>y)                                     | reet, factory, o                            | office   |                       | City or To                         |                                  |   | Thata Houle Namber,                                     |
| Div         | deatl<br>ctor:<br>/ the  | al Certification;     | 3 Suicide 6 Could no determine  | t be<br>ed 28e. Place of li<br>building, e  | etc. (Specif                           | y)   |   |  | <br>date and pla      | City or To                         | iwn, Stati                       | ə)  |   |
| Div         | deatl<br>ctor:<br>/ the  | edical Certification  | 3 Suicide 4 Homicide  6 Could no determine  | t be 28e. Place of li   | etc. (Specification of examina         | y)<br>wiedge, deat                                       | h occurred at                               | the time,  |                       | City or To                         | own, State                       | e)<br>) and manner                            | as stated.  |
| Div         |  | Medical Certification | 3 Suicide 4 Homicide  6 Could no determine  29a. Certifier (Check only 2 Medical Ex   | 28e. Place of Inbuilding, of Physician: To the best   | etc. (Specification of examina         | y)<br>wiedge, deat                                       | h occurred at vestigation, in               | the time,  | on, death oc          | City or To                         | own, State<br>cause(s<br>date an | e)<br>) and manner<br>d place, and c          | as stated.  |
| Vid         | To the Hospitel or Attention 24 hours after deall within 24 hours after deall completely filled in by the  | Medical Certification | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title et certifier                                      | 28e. Place of le building, c  | etc. (Specification of examina stated. | owledge, deat<br>tion and/or in                          | h occurred at ivestigation, in              | the time, of my opinion  | on, death od<br>umber | City or To                         | cause(s<br>, date an<br>29d. Da  | and manner<br>d place, and d<br>te signed (Mo | as stated.<br>due to the cause(s)                       |
| Div         | To the Hospitet or Attent within 24 hours after death within 24 hours after death To the Funeral Director: completely filled in by the                               | Medical Certification | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title effectiver 30. Name and address of person with    | 28e. Place of libuilding, see Physician: To the bestaminer: On the basis and mapper see the completed cause of        | st of my kno<br>of examina<br>stated.  | wiedge, deat<br>tion and/or in<br>(Type,                 | h occurred at ivestigation, in 29c. L       | the time, of my opinion in my opinion in the consent of the consen | on, death od<br>umber | City or To                         | cause(s<br>, date an<br>29d. Da  | and manner<br>d place, and d<br>te signed (Mo | as stated. due to the cause(s) onth, Day, Year)         |
| Div         | To the Hospitel or Attent within 24 hours after dealt to the Funeral Director: completely filled in by the   | Medical               | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title et certifier                                      | 28e. Place of led building.  Physician: To the bestaminer: On the basis and mapper such completed cause of D 801 Tol. | st of my kno<br>of examina<br>stated.  | owledge, deat<br>tion and/or in<br>3a) (Type,<br>See Ave | h occurred at ivestigation, in              | the time, of my opinion in my opinion in the consent of the consen | on, death od<br>umber | City or To                         | cause(s<br>, date an<br>29d. Da  | and manner<br>d place, and d<br>te signed (Mo | as stated. due to the cause(s) onth, Day, Year)         |

|   |                | 1 - For<br>State<br>Registrar  | State of Mar  |  | artment of<br>ertificate o                    |                                      |                                  | Reg. No.20                | 05 4243   |
|---|----------------|--|---|--|---|--------------------------------------|----------------------------------|---------------------------|---|
| Physic<br>/Med<br>Exami   | cal            | Decedent's Name (First, Middle, La:     ROY PAUL  4a. Facility Name (If not institution, give  | WHITBY  |  | 4b. City, Town                                | , or Location of De                  | 2. Date of D<br>Month<br>Decem   | ber 14                    | 3. Time of Dea<br><b>2005</b> /433<br>y of Death  |
| Funeral<br>Director   | lei            | 5. Social Security Number 6. S 217–30–8510   |   | Spital<br>Ith yrs. last birthday<br>Yrs.         |   | Easton<br>ar If Under 24 H           | rs. 8. Date of 8 (Month, L       | Ta                        | 9. Birthplace (State or Fo<br>Country)<br>MARYLAND                                      |
| n the Maryland<br>r 28a-f ehow  | tor            | Usual Residence of Decedent  10a, State  10b, County  QUEEN A  |   | Oc. City, Town or L                              |   |                                      |                                  |                           | 10d. Inside City Li<br>1 ☐ Yes 2 <b>½</b>   |
| h with the  | ai Directo     | 10e. Street and Number  205 WHITBY LANE  |   |  | 10f. Zip Code                                 | 21658                                |                                  | 10g. Citizen of US        | What Country?   |
| Maryland 21215-0036 d 2 should be filed within 72 hours after deeth with the Maryland the and Mental Hygiene. 27 le marked other then "natural", or items 23a or 28a-1 ehow traumatic event, the Medical Examinational conditional. | ted by Funeral | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ed   |   | 16a. Dece  | 1 Yes 2X N                                    | cupation                             |                                  | Specia                    | ce - American Indian, ack, White, etc.  fy: WHITE  Business/Industry                    |
| d 21215<br>filed within 7:<br>Hygiene.<br>other then "n   | Completed      | (Specify only highest gra  | College (1-4or 5+)  | life.  | e kind of work dor<br>DO NOT use reti<br>RMER | ne during most of w<br>ired)         | vorking                          | FARMIN                    |   |
| aryland 2<br>should be filed<br>nd Mental Hygi<br>marked other<br>amatic event, I   | To Be          | 17. Father's Name (First, Middle, Last) WALTER LEE WHITE   |   |  |   |                                      | ame (First, Middle<br>E MAE JO   | le, Maiden Sumai<br>NES   | me)   |
|   |                | 19a. Informant's Name/Relationship (   |   | 19b. Mail<br>205                                 | ing Address (Stre<br>WHITBY I                 | ANE, QUE                             | Rural Route Num<br>ENSTOWN,      | ber, City or Town MD 2165 | , State, Zip Code)<br>8   |
| OFF<br>Of H   |                | 20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  | Removal from State  | 20b. Place of Disp<br>cemetery, cre<br>STEVENSVI | matory or other p                             |                                      | Date -19-2005                    |                           | - City or Town, State   |
| Baltim permit. Pag Department Important: eny injury once.   |                | 21. Signature of Funeral Service Licer   | Raci  | 8 1 4  | 08 S. ĹI                                      | BERTY ST                             | ., CENTR                         | EVILLE,                   | RAL HOME, P.A.<br>MD 21617  |
| SX 68760, Centificate be executed Centificate be executed Control of the private as the burial-transit  | dical Examiner | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last |   | Consequence of): O(NTENST) consequence of):      |   |                                      |                                  | arrest,                   | Approximate Interval Between Onset and Death  |
| Geath death of for u  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome of<br>1 □ Live birth 2 [<br>4 □ Pregnant at tin<br>9 □ Unknown | Fetal death 3                                    | □Ectopic pregnar □ Other (specify)            |                                      |                                  |                           | ate of delivery<br>onth Day Year  |
| ords, P.O requires that the een signed by th rould be detache   | b              | Part II. Other significant conditions c  | ontributing to death but r  | not resulting in the u                           | underlying cause                              | given in Part I.                     |                                  | tobacco use con           | tribute to the cause of death   |
| I Rec   | Completed      |  |   |  |   |                                      | 24a. Wa<br>auto<br>per<br>1  Yes | opsy<br>formed?           | Were autopsy findings avails<br>prior to completion of cause<br>death?<br>1 ☐ Yes 2 WNo |
| of Vital Physicien: 1 this certificat ral director, p.  | To Be          | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | Hospital: 1 Inpatient   | 2 ER/Outpatie                                    | nt 3 DOA                                      | 26. Place of D<br>Other: 4 ☐ Nursing | eath Check only Home 5 Res       |                           | ner (Specify)   |
| ISION O   | Certification: | 27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be   |   |  | of 28c. In W                                  | jury at<br>/ork?<br>□ Yes 2 □ No     | 28d. Describe                    | how injury occur          | red   |
| Division To the Hospitel or Attent within 24 hours efter deatt To the Funeral Director: completely filled in by the   | i Certif       | 4 Homicide determined  | building, etc. (  | Specify)   |   |                                      | City or To                       | own, State)               | ber or Rural Route Number,  |
| he Hos<br>in 24 h<br>ihe Fun<br>pletely   | edicai         | (Check only 2 Medical Examone)   | niner: On the basis of ex<br>and manner stated                                      | camination and/or in                             | ivestigation, in my                           | y opinion, death oc                  | curred at the time               | , date and place,         | and due to the cause(s)   |
| To the within 2 To the complet  | 2              | 29b. Signature and title of certifier  |   |  |   | nse number<br>005948                 | 7                                | _                         | d (Month, Day, Year)  |
| BKK   |                | 30. Name and address of person who JOHN BOTSIS, M  | completed cause of deat .D., 219 S.   | WASHING  | Print)  |                                      |                                  | 12-14                     | -05   |
| Sta<br>Regist   |                | 31. Date filed (Month, Day, Year)  NFC 15  | 32. Registrar's   |  | have.   |                                      |                                  |                           |   |

|   |                   | For State Registrar  | State of Marylar   |                                    |             |                          | ealth and N<br>Death                                 | nental Hy                              | rgiene<br>Reg. Nps () ()   | 5 Pr=                            | 10100  |
|---|-------------------|--|--|------------------------------------|-------------|--------------------------|--|--|--|----------------------------------|--|
| T 87%   |                   | Decedent's Name (First, Middle, Last)  |  |                                    |             |                          |  | 2. Date of De                          | aath ZU  | Year                             | 3. Time of Debti                                 |
| Physic  |                   | Erma Lou   | ise Wat  | son                                |             |                          |  |  | er 20, 2   |                                  | 10:48 a.M  |
| /Medi<br>Examir   |                   | 4a. Facility Name (If not institution, give s  |  |                                    | 4b. City    | Town, or                 | Location of Death                                    |  | 4c. County   | of Death                         |  |
| Exami   | ie:               | 39240 Persimmon (  |  |                                    |             | Mech.                    | anicsvil   | le                                     | St   | . Ma                             | ry's   |
| Eurovali  | 100               | 5. Social Security Number 6. Sex   |  | . last birthday)                   | If Unde     | 1 Year                   | If Under 24 Hrs.                                     | 8. Date of Bi                          | rth  |                                  | place (State or Foreign<br>intry)                |
| Funeral Director  |                   | 214-42-4574  | IM 2 <b>■</b> F 83   | Yrs.                               | Months      | Days                     | Hours Min.   | (Month, Da                             | 2, 1922  |                                  | vland  |
|   |                   | Usual Residence of Decedent  |  |                                    |             |                          |  |  |  |                                  |  |
| land  |                   | 10a. State 10b. County   | 10c. C   | ity, Town or Lo                    | cation      |                          |  |  |  |                                  | 10d. Inside City Limits                          |
| Man,  | ŏ                 | Maryland St. Mary  | ,1 ,   | Ma                                 | chan        | icev                     | i11e   |  |  |                                  | 1 ☐ Yes 2 图 No                                   |
| 28a   | Director          | 10e. Street and Number   | 5  | 110                                |             | Code                     | 1110   |  | 10g. Citizen of V  | What Cou                         | intry?   |
| with a or   |                   | 202/0 7  | 1. D 1   |                                    |             | 2                        | 0659   |  | United   | C+ a                             | tos  |
| e 23  | eral              | 39240 Persimmon (  | 12. Was Decedent Ever in U   | II.S 13.3                          | Was Dece    |                          |  | pecify Yes or N                        |  |                                  | ican Indian,                                     |
| be filed within 72 hours after death with the Maryland Mal Hygiene. ad other than "natural", or iteme 23a or 28a-f show event, the Madisal Examinar must be notified at | by Funeral        | 11. Marital Status  1 □ Never Married 2 □ Married  3 🔁 Widowed 4 □ Divorced  | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:                                 |                                    | f Yes, spe  |                          | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | Rican, etc.)                           | Specify  | k, White                         |  |
| 2 hou   | Completed t       | 15. Decedent's Edu   | cation   | 16a. Dece                          | dent's Usu  | al Occupa                | ation<br>during most of work                         | king                                   | 16b. Kind of Bu  | usiness/lr                       | ndustry  |
| 7 nin 7<br>n 'n<br>Madi   | ple               | (Specify only highest grade<br>Elementary/Secondary (0-12)   | College (1-4or 5+)   | life.                              | DO NOT      | se retired               | i)   | ang.                                   | A. Control of the Con |                                  |  |
| filed within<br>Hygiene.<br>other than "  | E                 | Lioinidaly, 3333, aut y (5 12)   | 2  |                                    | Nu          | rse                      |  |  | N  | ursi                             | ng   |
| Hygie<br>Hygie<br>other   | 0                 | 17. Father's Name (First, Middle, Last)  |  |                                    |             |                          | 18. Mother's Nam                                     | ne (First, Middle                      | e, Maiden Suman  | 10)                              |  |
| Mental<br>Mental<br>arked o   | OD                | Walter Buckmaster  |  |                                    |             |                          | Tda  | Louise                                 | Hardest  | v                                |  |
| es 1 and 2 should be of Health and Menta Iltem 27 le marked rother traumatic ev   | To                | 19a, Informant's Name/Relationship (Ty   |  | 19b. Mailir                        | ng Addres   | s (Street                | and Number or Ru                                     |  |  | <del></del>                      | ip Code)   |
| 12 s<br>h an<br>7 le i  |                   |  |  | 1                                  | _           |                          |  |  |  |                                  | le, MD 206                                       |
| tealt<br>tealt<br>im 2  |                   | James Raley / Son<br>20a. Method of Disposition  |  | · Avancary                         |             |                          |  | Date Date                              | 20c. Location -  |                                  |  |
| of F  |                   | 1 ■ Burial 2 □ Cremation 3 □ F   | emoval from State  | Place of Dispo<br>cemetery, crei   | natory or   | other plac               | 7  |  | 1  |                                  |  |
| permit. Pages 1 Department of H Importent: If Ite any injury or ot  |                   | 4 □Donation 5 □ Other (Specify)  | Pa   | norama                             | Mem.        | Gdn                      | s. 12-23   | 3-2005                                 | Strasbu  | rg,                              | Virginia   |
| permit. Pag<br>Department<br>Importent: I<br>any injury o   |                   | 21. Si ral envice Licens   | e )  | B1                                 | Name a      | nd Addres                | ss of Facility<br>-Echols                            | Funeral                                | Home, P  | . A .                            |  |
| 9 9 E 2 9   |                   | Edward N. Brinsfie   | 1d. Jr. MO   |                                    |             |                          | e Notch 1  |  |  |                                  | . MD 20622                                       |
|   |                   | 23a. Part1. Enter the disease, or compl<br>shock, or heart failure. List only of   | cations that caused the de-  | ath. Do not ent                    | er the mo   | de of dyin               | g, such as cardiac                                   | or respiratory                         | arrest,  |                                  | Approximate<br>Interval Between                  |
| cate be executed Examiners by sician and sthe burial-transit  | al Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consection).  Due to (or as a consection).  Due to (or as a consection). | эднэгоэ эП:                        |             |                          |  |  |  |                                  |  |
| death certificate<br>e attending phys<br>id for use as the  | Physician/Medical | 23b. was decedent pregnant   | 3c. If yes, outcome of preg  |                                    | ∃Ectopic    | regnancy                 | ,  |  |  | te of deliver                    | very<br>Day Year                                 |
| 0 80 0  | ysich             | in the past 12 months?<br>1 □ Yes 2 ☑ No<br>9 □ Unknown  | 4☐Pregnant at time of<br>9☐ Unknown  | death 5                            | Other (s    | pecity)                  | 324  |  | 100  |                                  | Day Tour   |
| that the detail   |                   | Part II. Other significant conditions co   | ntributing to death but not re   | esulting in the u                  | inderlying  | cause giv                | en in Part I.  | 23e. Did                               | tobacco use cont   | tribute to                       | the cause of death?                              |
| sign<br>d be  | d by              |  | -  |                                    |             |                          |  | 1 🗆                                    | Yes 2□No   | 3 🗆 Pro                          | bably 4 Unknow                                   |
| The law requires that the ate has been signed by the page 2 should be detached  | Completed         |  |  |                                    |             |                          |  |  | opsy   | Were aut<br>prior to c<br>death? | topsy findings availab<br>completion of cause of |
| lcian: The l<br>certificate ha  |                   | 7.00   | -  | 810                                |             |                          |  |  |  | 1 🗌 Yes                          | 2 🛛 No   |
| ysician:<br>is certific<br>director,  | Be                | 25. Was case referred to medical examiner?   | dosnital:  |                                    |             | I ou                     | 26. Place of Dea                                     |  |  | _                                |  |
| S 0 5   | 2                 | 1 1 492 STA140   |  | ☐ ER/Outpatie                      |             |                          | 4 🗆 Huising I  | /                                      | sidence 6 Oth  |                                  | cify)  |
|   |                   | 27. Manner of Death<br>1 XNatural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time o                        |             | 28c. Injur<br>Wor        |  | 28d. Describe                          | how injury occur   | rea                              |  |
| Attending ir death.  ctor: After by the fune  | catio             | 2 Accident investigation 3 Suicide 6 Could not be  | On Diese of leive. At  | home form at                       | M           |                          | Yes 2 □ No   | 28f Location                           | /Street and Numb   | ner or Pu                        | ral Route Number,                                |
| i Lite  | Certification:    | 4 Homicide determined  | 28e. Place of Injury - At building, etc. (Spec   | cify)                              | reet, racto | ry, onice                |  | City or To                             | own, State)  | JOI OI NE                        | iai riobie reumber,                              |
| To the Hospital or Attend within 24 hours after deatl To the Funeral Director: completely filled in by the  | edical C          | 29a. Certifier Certifying Phy<br>(Check only 2 Medical Exam  | sician: To the best of my k<br>iner: On the basis of exami<br>and manner stated.         | nowledge, deat<br>nation and/or in | th occurre  | at the tir<br>n, in my c | me, date and place<br>pinion, death occu             | o, and due to the<br>urred at the time | e cause(s) and ma<br>a, date and place,  | anner as<br>and due              | stated.<br>to the cause(s)                       |
| o th<br>o th<br>o th  | ₹                 | 29b. Signature and title of certifier  | 4  |                                    | 2           | c. Licens                | e number   |  | 29d. Date signe  | d (Month                         | n, Day, Year)                                    |
| ⊢≯⊢ŏ  |                   |  | Zuah   |                                    | •           | D                        | 4706   | 6                                      | 12.20  | . 0                              | S  |
|   |                   | , 3  |  | om 33a\ (T: -                      | Dei-4       |                          | 11   |  |  |                                  |  |
|   |                   | 30. Name and address of person who c   |  |                                    |             |                          | т 1.   |  | 1 1 1  | 2075                             | 0  |
|   |                   | Avani D. Shah, M   |  |                                    | ne Co       | urt,                     | Leonardi   | cown, Ma                               | aryland :  | ZU65                             | U  |
| SE 0  | ate               | 31. Date filed (Month, Day (Year) 20   | 37 Registrar's Sig   | nature                             | 2016        | ı                        |  |  |  |                                  |  |

|                                |   |                 | 1- For State of Maryland  | / Department of Health a<br>Certificate of Death                  |                         | 6007                          | 42437   |
|--------------------------------|---|-----------------|---|---|-------------------------|-------------------------------|---|
|                                |   |                 | Decedent's Name (First, Middle, Last)   |   | 2. Date of I            | Rag. No.                      | 3. Time of Death                                |
| ı                              | Physici<br>/Medi  |                 | EDWARD E. W   | HITE  | Dec.                    | 12,2005 Year                  | 6:45a M   |
|                                | Examir  |                 | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of                                    |                         | 4c. County of Dea             |   |
| н                              |   |                 | 1836 Metzerott Rd. #1009  | Hyattsvill  | ا و                     | Prince                        | Coomma  |
|                                | Funeral   |                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last   |   | 24 Hrs. 8. Date of E    | Birth 9 Ri                    | tholage (State or Foreign                       |
| п                              | Director  |                 | 244-48-2679 1XM 2DF 70  | Yrs. Months Days Hours  |                         | 6,1935 No                     | cth Carolir                                     |
|                                | pun *   |                 | Usuel Residence of Decedent  10a. State 10b. County 10c. City. T  | Fown or Location  |                         |                               |   |
|                                | Aaryla<br>F sho   | ö               |   | ttsville  |                         |                               | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No          |
|                                | 289-1   | Director        | 10e. Street and Number  | 10f. Zip Code   |                         | 40-00                         |   |
|                                | with<br>Ba or   |                 | 1836 Metzerott Rd. #1009  | 20783   | 1                       | 10g. Citizen of What C        | ountry?   |
|                                | ns 23   | Funeral         | 11. Marital Status 12. Was Decedent Ever in U.S.  |   |                         |                               | erican Indian                                   |
| G                              | or Iter   | Fu              | Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 🖫 Yes 2 ☐ No  | 13. Was Decedent of Hispanic Orig                                 |                         | Black, Whi                    |   |
| Š                              | ours a  | þ               | 3 ☐ Widowed ♣️ŒDvivorced If Yes, Give<br>Year or Dates:   | 1 ☐ Yes 2 No Specify:   |                         | Specify: b1                   | ack   |
| 2-0                            | within 72 hours after death with the Maryland one. then "naturel", or Items 23a or 28e-f show then "naturel", or Items 23a or 28e-f show the Madical Exertiner ast be retitled at | Completed       | 15. Decedent's Education (Specify only highest grade completed)   | 16a. Decedent's Usual Occupation                                  | t of working            | 16b. Kind of Business         | /Industry                                       |
| 21                             | ithin   | μď              | Elementary/Secondary (0-12) College (1-4or 5+)  | (Give kind of work done during most life. DO NOT use retired)     |                         | Dry Cle                       | aning   |
| 2                              |   |                 | 17. Father's Name (First, Middle, Last)   | <del>-</del>  | leaners                 |                               |   |
| anc                            | I be fited<br>ntal Hygi<br>ed other<br>event, I   | Be              | Rommie White  |   | er's Name (First, Middl |                               |   |
| Ž                              | 2 should be and Mental is marked creumatic even   | ၉               |   | Lil.  |                         |                               |   |
| Ma                             | and 2 s<br>ealth an<br>n 27 is<br>ler treu  |                 |   | 19b. Mailing Address <i>(Street and Numbe</i><br>13938 Alderton I | Rd Silve                | per, City or Town, State, .   | Zip Code)<br>Md 2000                            |
| ē,                             | tem (   |                 | 20a. Method of Disposition 20b. Place   | e of Disposition (Name of   | Date                    | 20c. Location - City or       |   |
| 9                              | Pages<br>nent of<br>snt: If it  |                 | 1 ☑ Burial 2 □ Cremation 3 □ Removal from State Harmo   | etery, crematory or other place) ony Memorial                     | 12/17/05                | Landover,                     |   |
| Baltimore, Maryland 21215-0036 | - E # -   |                 | 21. Signature of Feneral Service Liber see  | 22. Name and Address of Facility                                  |                         |                               |   |
| ä                              | Depare Impo   |                 | 1/2 / nat 064   | 411 Kennedy S   | St.N.W.                 | Washingto                     | y 20011   |
|                                |   |                 | 23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. | Do not enter the mode of dying, such as o                         | cardiac or respiratory  | arrest,                       | Approximate                                     |
| z                              | Physician   |                 | Immediate Cause (Final disease or condition   |   |                         |                               | Interval Between<br>Onset and Death             |
|                                | /Medical  |                 | resulting in death)  a.  Due to (or as a consequence)   | ce of):   | m :                     |                               |   |
|                                | Examiner  |                 | Sequentially list conditions, b.  | ral Concer.   |                         |                               |   |
|                                | pe is   | ine             | if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury  | ce of):   |                         |                               |   |
|                                | and<br>I-tran   | Examiner        | that initiated events c.  Pue to (or as a consequence)  | no of):   |                         |                               |   |
| 8760,                          | cate be executed<br>physician and<br>the burial-transit   | aiE             | Due to (of as a consequent  | Je 01).   |                         |                               |   |
| 687                            | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit                | edicai          | d   |   |                         |                               |   |
|                                | leath certific<br>attending p   | /W              | IF FEMALE: 23c. If yes, outcome of pregnancy  |   |                         | 23d. Date of del              |   |
| Box                            | death<br>e atte   | Iclai           | in the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ Live birth 2 ☐ Fetal death  |   |                         | Month Month                   | Day Year  |
| 0.                             | that the de<br>led by the a<br>detached t   | by Physician/Me | 9 ☐ Unknown 9☐ Unknown  |   |                         |                               |   |
|                                | res tha<br>igned<br>be det  | by P            | Part II. Other significant conditions contributing to death but not resulting   | g in the underlying cause given in Part I.                        | 23e. Did                | tobacco use contribute to     | the cause of death?                             |
| ord                            | w require<br>been si<br>should b  |                 |   |   | 10                      | Yes 2. No 3 ☐ Pr              | obably 4 Unknown                                |
| Records,                       | has be  | Completed       |   |   | 24a. Was                |                               | topsy findings available completion of cause of |
|                                | ysicien: The is certificate hidirector, page  | Con             |   |   | perf                    | ormed? death?<br>2⊠No 1 □ Yes |   |
| Vital                          | icien: Th<br>certificate<br>rector, pag   | Be              | 25. Was case referred to medical examiner?  |   | of Death (Check only    |                               |   |
| ot                             | Physical direction  | 2               |   |   |                         | idence 6 Other (Spec          | city)   |
| Division of                    | ding I  | lon             | 1 Natural 5 Pending (Month, Day Year)   | b. Time of 28c. Injury at Work?  M 1 Yes 2 N                      |                         | how injury occurred           |   |
| S                              | Attendi<br>death.<br>ctor: A<br>y the fu  | licat           | 2 Accident investigation 3 Suicide 6 Could not be determined elemined   |   |                         | Street and Number or Ru       | -18   |
| 2                              | after<br>after<br>Dire  | Certification;  | 4 Homicide determined building, etc. (Specify)  | tami, stroot, factory, office                                     | City or To              | wn, State)                    | rai Houte Number,                               |
|                                | To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director,                |                 | 29a. Certifier 1 Certifying Physician: To the best of my knowled  | dge, death occurred at the time, date and                         | place, and due to the   | cause(s) and manner as        | stated  |
|                                | he Hc<br>n 24  <br>he Fu<br>sietely   | Medical         | (Check only 2 Medical Examiner: On the basis of examination one)  | and/or investigation, in my opinion, death                        | n occurred at the time, | date and place, and due       | to the cause(s)                                 |
|                                | Comp  | ž               | 29b. Signature and title of certifier   | 29c. License number   |                         | 29d. Date signed (Month       | , Day, Year)                                    |
|                                | 15)   |                 | I chun Thin   | M D00618  | 90                      | 12/14/                        | 5   |
|                                | 9   |                 | 30. Name and address of person who completed cause of death (Ilen 23a   |   |                         | 1.1/0                         |   |
|                                | S\$ (   |                 | Anuradha Dahiya, MD 12201 Pl  | um Orchard Dr.,   | Silver S                | pring, MD                     | 20904   |
|                                | Sta:<br>Registra  |                 | 3) Date filed (Month, Day, Year) 32. Registrar's Signature  |   |                         |                               |   |
|                                | riegistr  | 11              | - LOUI MOBILE TO GOOD   | ν   |                         |                               |   |

| rn   |                            | 1- For State Registrar Amend#21.22.  | State of  | Mandar                            | nd / Den                             | artment                         | of H  | ealth and l  | Mental Hyg                                   |                      | 005  | 424                           | 38                  |
|--|----------------------------|--|---|-----------------------------------|--------------------------------------|---------------------------------|---|--|--|----------------------|--|-------------------------------|---------------------|
| Physicia   |                            | Decedent's Name (First, Middle, Last)     DOROTHY  |   |                                   |                                      | INGTO                           |   |  | 2. Date of Dea<br>Month<br>December          | th                   | , 2005   | 3. Time of 0                  | Death<br>A N        |
| /Medica<br>Examine   |                            | 4a. Facility Name (If not institution, give s<br>Prince George's Ho  |   |                                   | r                                    | , ,                             |   | Location of Death $= 1 y$                          |  | 4c.<br>Pr            | County of Death                                      | rge's                         |                     |
| Funeral<br>Director  |                            | 5. Social Security Number 577-50-8184  Usual Residence of Decedent   | 7<br>]M 2∏∑F  |                                   | last birthday)<br>66 Yrs.            | If Under 1<br>Months            |   | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth<br>(Month, Day)<br>06/06/   | 193                  | 9. Birthp<br>Coun<br>Mary                            | lace (State or<br>to)<br>Land | Foreig              |
| death with the Maryland<br>ma 23e or 28e-f show<br>rmast te notified at  | tor                        | 10a. State 10b. County  District of Column   | umbia   |                                   | ty, Town or Lo                       |                                 | <u>, , , , , , , , , , , , , , , , , , , </u> |  |  |                      | 11   | 0d. Inside City               |                     |
| ath with the Marylar<br>23a or 28a-! show  | i Directo                  | 10e. Street and Number 5305 Dix St., N   | .E.   |                                   |                                      | 10f. Zip (                      | Code<br>2001                                  | 19   | 1  | 0g. Citi             | zen of What Coun                                     | itry?                         |                     |
| 5 <b>2</b> 2   | by Funeral                 |  | 12. Was Deced<br>Armed Ford<br>1 Tes 2<br>If Yes, Give<br>Year or Dai | es?<br>No                         |                                      | Was Decede                      |   | spanic Origin? (S<br>n, Mexican, Puert<br>Specify: | pecify Yes or No-<br>to Rican, etc.)         |                      | 14. Race - Americ<br>Black, White, of<br>Specify: B1 | etc.                          |                     |
| 1215-0036 within 72 hours after ene. than "naturel", or its the Medical Energing   | Be Completed               | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0·12)   | cation<br>e completed)<br>College (1-                                 | 4or 5+)                           | 16a. Dece<br>(Give<br>life.          |                                 |   | ation<br>furing most of wor                        | rking  | 16b. Ki              | nd of Business/Ind                                   |                               |                     |
| be filed tal Hyging of other   | To Be Cor                  | 12<br>17. Father's Name (First, Middle, Last)<br>Johnnie   | 2   | Mi                                | tchel                                | Hou                             | sek   | eeping  18. Mother's Nam  Florer                   | me (First, Middle, I                         | Maiden               |  | e<br>rcer                     |                     |
| Mary nd 2 shou lith and M 27 is mar r troumati   | -                          | 19a. Informant's Name/Relationship (Ty) Debra Taylor (   |   | cer)                              |                                      |                                 |   | ind Number or Ru                                   | ral Route Number                             |                      |  |                               | )                   |
| more, M<br>Pages 1 end 2<br>nent of Health<br>nt: If Item 27 i   |                            | 20a. Method of Disposition  1 XBurial 2 Cremation 3 R  4 Donalion 5 Dother, (Specify)  |   | 20b. I                            | Place of Dispo<br>cemetery, crei     | sition (Name                    | e of<br>ner place                             | 9)   |  | 20c. Lo              | cation - City or To                                  | wn, State                     |                     |
| Baltimor<br>permit. Pages<br>Department of I<br>Importent: If its<br>any injury or or  |                            | 21. Signature Fune al Service License  |   | W. 11                             | I St                                 | Name and<br>Ewart<br>1001       | Addres<br>F.F<br>Ben                          | s of Facility Jo<br>ning Ro                        | erdan Fu                                     | ine:                 | ral Ser  | vice,<br>2001                 | <del>In</del><br>9) |
| 76(<br>ta be<br>ysicia   | dicai Examiner             | 23a. Part1. Enter the disease, of compliance shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list nondition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (o   |                                   | Arter:<br>quence of):<br>quence of): |                                 |   |  | ovascular                                    |                      | sease  | Onset and De                  | eath                |
| vision of Vital Records, P.O. Box 68 Attending Physician: The law requires that the death certificat cleath.  octor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the | Completed by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼ Unknown  |   | th 2∏Feta<br>ntattime of o        | al death 3[                          | Ectopic pre                     |   |  |  | 2                    | 23d. Date of deliver<br>Month                        |                               | 9 <b>a</b> r        |
| Cords, P. wrequires that been signed be should be deta   | ed by Pr                   | Part II. Other significant conditions con<br>Congestive Heart  |   |                                   |                                      |                                 | use give                                      | on in Part I.                                      |  |                      | se contribute to the                                 | 37                            |                     |
| Division of Vital Records, P.O. or attending Physician: The law requires that the diattar death.  Director: Atter this certificate has been signed by the funeral director, page 2 should be detached.   | Complet                    |  |   |                                   |                                      |                                 |   |  | 24a. Was a autops perform                    | v                    | 24b. Were autop<br>prior to con<br>death?<br>1  Yes  |                               | vailat<br>use o     |
| of Vital F Physician: Th this certificate al director, pag   | To Be                      | 25. Was case referred to medical examiner?  1 Xes 2 No   | lospital: 1 🗆 Inj   | patient 2X                        | ] ER/Outpatier                       | nt 3 DOA                        | Othe  | _  | ath <i>(Check only on</i><br>lome 5 ☐ Reside |                      | ☐Other (Specify                                      | )                             |                     |
| sion o<br>suding Ph<br>ath.<br>or: After th  | ation:                     | 27. Manner of Death  1   | 28a. Date of<br>(Month,   | Injury<br>Day Year)               | 28b. Time o<br>Injury                | f 28                            | c. Injury<br>Work<br>1 🔲 Y                    | at<br>?<br>∕es 2∐No                                | 28d. Describe ho                             | w injury             | occurred   |                               |                     |
| Div<br>Ital or<br>ral Dire<br>led in t   | Certification:             | 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of<br>building   | f Injury - At h<br>j, etc. (Speci | ome, farm, str<br>fy)                | eet, factory,                   | office  |  | 28f. Location (St.<br>City or Town           | reet and<br>, State) | d Number or Rural                                    | Route Number                  | θΓ,                 |
| The Hospital<br>in 24 hours in<br>the Funeral<br>pletely filled  | Medicai                    | 29a. Certifier (Check only one)  1☐ Certifying Phys 2☐ Medical Examir  | sician: To the base.  Ter: On the base and manner.                    | is of examina                     | owledge, deatl<br>ation and/or in    | h occurred at<br>vestigation, i | t the tim<br>n my op                          | e, date and place<br>inion, death occu             | , and due to the ca<br>rred at the time, da  | use(s)<br>ate and    | and manner as sta<br>place, and due to               | ated.<br>the cause(s)         |                     |
| To the within 2 To the complei   | Σ                          | 29b. Signature and title of certifier  | D   |                                   |                                      | 29c.                            |   | .C.M.E.  |  |                      | e signed (Month, E<br>ember 10,                      |                               |                     |
| of (3)   |                            | 30. Name and address of person who co<br>J. Laron Locke, M   |   | of death (Iter                    |                                      |                                 | St  | reet, Ba   | ltimore,                                     |                      |  |                               |                     |
| Stat<br>Registra   |                            | 31. Date filed (Month, Day, Year) DEC 1 5 2005   | Rec. Rec  | gistrar's Signa                   | ature                                | E)                              |   |  |  |                      |  |                               |                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🖔 For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0438 A 2005 WOULARD DECEMBER 15 LENIS CHELTIN /Medical 4a. Facility Name (If not institution, give streat and number) or Location of Death 4c. County of Death 4b. City, Town, Examiner Hopking 6. Sex 7m0/0 Baltimore Age (In yrs. last birthday) Johns If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Year Date of Birth (Month, Day, Social Security Number **Funeral** Days Months 1 M 2 □ F 48 Director 02 11957 Florida 221-46-0395 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State 28e-f ehow other traumatic event, the Medical Examinar must be notified at 1 THYES 2 No New Castle Directo DE )Ilmington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9 Iteme 23a States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a eny injury or other traumatic event, the Madical Exzor and must once. Woodlawn 19805 315 Avenue Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1977 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Employed Genera abor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 4)oulard Owens hester Clarence Doroth 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy Woulard (mother 19805 Wilm, DE Woodlawn Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22 05 Silverbrook. 4 ☐ Donation 5 ☐ Other (Specify) Cemeter Wilmington 22. Name and Address of Facility DOI N. Gray Ave. 21. Signature of Funeral Se ce Licensee 19805 Congo Funeral Home complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the dise shock, or heart failur Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Fungal Infection' month disease or condition resulting in death) /Medical Due to for as a consequence of): Examiner stage months End Failure LIVEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit Hupanns infection B years ed by the ettending physician and detached for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death in the past 12 months? Month Year Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown this certificate has been signed by rail director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 or Attending Physicien: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 2 No Certification: To 1 🗌 Yes 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 TYes 2 No death. investigation 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MND RES - 000 DECEMBER 15 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATINE JALKSON MO JOHNS HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State well Registrar

DHMH 17 Rev 1/2001

ORIGINAL

|                                 |  | n V                  | Jinkelman  |   |                                  |  |                                      |  |                                      |                       |                                       |                                     |
|---------------------------------|--|----------------------|--|---|----------------------------------|--|--------------------------------------|--|--------------------------------------|-----------------------|---------------------------------------|-------------------------------------|
| 05-086<br>d1                    |  |                      | Please<br>Amend Unper  | Type or Prind<br>item#1,23a<br>State of Ma                        | 1t in E<br>,27, p                | Black Inc<br>en E. C85   |                                      | k_Ensure A                                     | All Copie:                           | s Are                 | Legible.                              |                                     |
|                                 |  |                      | 1 - For State Registrar  | State of Mi   | ai yiai                          |  | tificate o                           |  | vientai i i                          | Reg. N                | CHUS                                  | 42440                               |
|                                 | Physici  | an                   | 1. Decedent's Name (First, Middle, La  | st)   |                                  |  | -                                    |  | 2. Date of D                         |                       | ay Year                               | 3. Time of Death                    |
|                                 | /Medic   | caf                  | TIMOTHY WINKELMA   |   |                                  |  |                                      |  | Decem                                | ber                   | 21, 2005                              |                                     |
| 200                             | Examin   | ier                  | 4a. Fecility Name (If not institution, giv                                       |   |                                  | 1  |                                      | , or Location of Death                         | 1                                    |                       | c. County of Dea                      |                                     |
| 2                               | Funeral  |                      | Laurel Regional I 5. Social Security Number 6. S                                 | Sex 7. Ag   | e (In yrs.                       | last birthday)   | If Under 1 Year<br>Months Day        |  |                                      | irth                  | 9 Rin                                 | thplace (State or Foreign           |
| 00                              | Director   |                      | 213-88-8983 Usual Residence of Decedent  |   | 41                               | Yrs.   |                                      |  | 03/21/                               | 1964                  | Was                                   | hington, DC                         |
|                                 | nyland<br>how  |                      | 10a. State 10b. County   |   | 10c. Cit                         | y, Town or Lo  | ation                                |  |                                      |                       |                                       | 10d. Inside City Limits             |
|                                 | Ba-f •   | Director             | Maryland Anne Aru  | nde1  | Lau                              | re1  | T = 2 .                              |  |                                      |                       |                                       | 1 X Yes 2 □ No                      |
|                                 | with t   |                      | 10e. Street and Number 3285 Fort Meade R   | ood #24   |                                  |  | 10f. Zip Code 20724                  | •  |                                      | USA                   | itizen of What Co                     | ountry?                             |
|                                 | death  | Funeral              | 11. Marital Status   | 12. Was Decedent  | Ever in U                        | .S. 13. V  | Vas Decedent o                       | of Hispanic Origin? (S<br>uban, Mexican, Puert | pecify Yes or N                      |                       | 14. Race - Ame<br>Black, Whit         |                                     |
| Maryland 21215-0036             | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itema 23a or 28a-f show sumatic event, the Medical Examiner must be multiled at   | þ                    | 1XXXIever Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced                        | Armed Forces?  1  Yes 2 Y  If Yes, Give Year or Dates:            | No                               | i i  | □Yes <b>XX</b> N                     |  | 3 ( 11541), 5(6.)                    |                       | Specify:                              | ite                                 |
| 15-0                            | I within 72 hours<br>jiene.<br>r then "neturel",<br>ibe Medicel Ex   | Completed            | 15. Decedent's E<br>(Specify only highest gra                                    | ducation<br>ade completed)  |                                  | 16a. Deced   | ent's Usual Occ                      | cupation<br>ne during most of wor<br>ired)     | king                                 | 16b. l                | Kind of Business                      | Industry                            |
| 212                             | iene.<br>r than  | ошо                  | Elementary/Secondary (0-12)  | College (1-4or 5  | i+)                              | Techni   |                                      | rea)   |                                      | Gi                    | iant Foo                              | d                                   |
| P 2                             | at Hyg<br>t other  | BeC                  | 17. Father's Name (First, Middle, Last   |   |                                  | ,  |                                      | 18. Mother's Nan                               |                                      |                       | n Sumame)                             |                                     |
| <u> </u>                        | ould to marked narked  | To                   | Melvin A. Winkel   |   |                                  | 1 401 14 11  |                                      | Beatric  |                                      |                       |                                       |                                     |
| Mai                             | コモトラ   |                      | 19a. Informant's Name/Relationship ( Rus Maxwe11/ Bro                            |   |                                  | 1  |                                      | et and Number or Ru<br>nountRoad               |                                      |                       |                                       | Zip Code)                           |
| Baltimore,                      | ss 1 and<br>of Heelt<br>item 2<br>r other  |                      | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □                          |   | 20b. F                           | Control of the Contro | sition (Name of<br>atory or other p  |  | Date                                 |                       | ocation - City or                     | Town, State                         |
| iii                             | Page<br>ment<br>ant: If  |                      | 4 □ Donation 5 □ Other (Specil   |   |                                  | ntt Cre  | matory                               | 12/2   | 4/2005                               |                       | dorf, M                               |                                     |
| Ball                            | permit. Pages 1 s Department of He Important: If item eny injury or oth  |                      | 21. Signature of Funeral Service Licer   | nsee  |                                  |  |                                      | dress of Facility Ro                           |                                      |                       |                                       | ral Home                            |
|                                 |  |                      | 23a. Part1. Enter the disease, or comshock, or heart failure. List only          | plications that caused  | the deat                         | -  |                                      |  |                                      |                       | D 20/13                               | Approximate                         |
|                                 | Physician  |                      | Immediate Cause (Final disease or condition                                      | a Complicat   |                                  | of Chroni  | c Alcoho                             | lism   |                                      |                       |                                       | Interval Between<br>Onset and Death |
|                                 | /Medical<br>Examiner   |                      | resulting in death)  | Due to (or as   |                                  |  |                                      |  |                                      |                       |                                       |                                     |
|                                 |  | er                   | Sequentially list conditions,  Tany leading to immediate cause. Enter Underlying | b. Due to (or as  | a consec                         | uanca of):   |                                      |  |                                      |                       |                                       |                                     |
|                                 | cuted<br>nd<br>ransit  | amlner               | that initiated events  | с.  |                                  |  |                                      |  |                                      |                       |                                       |                                     |
| 90,                             | be exection and burial-tr  | EX                   | resulting in death) Last   | Due to (or as   | a conseq                         | uence of):   |                                      |  |                                      |                       |                                       |                                     |
| 387(                            | tificate by<br>ng physical<br>as the b   | dlca                 |  | _ d   |                                  |  |                                      |  |                                      |                       |                                       |                                     |
| Box 68760,                      | ath certif   | In/Me                | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome  |                                  |  | Ectopic pregnar                      |  |                                      |                       | 23d. Date of del                      | ivery                               |
| B                               | e deatl  | by Physician/Medical | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                          | 4☐Pregnant at   |                                  |  | Other (specify)                      |  |                                      |                       | Month                                 | Day Year                            |
| 9.                              | thet the de<br>ed by the<br>detached   | / Ph                 | Part II. Other significant conditions of   | contributing to death b   | ut not res                       | ulting in the un   | derlying cause o                     | given in Part I.                               | 23e. Did                             | tobacco               | use contribute to                     | the cause of death?                 |
| rds                             | w requires to been signer should be  |                      |  |   |                                  |  |                                      |  | 1 🗆                                  | Yes 2                 | 2 □No 3 □ Pr                          | obably 4 Unknown                    |
| ဝပ္ပ                            | law re<br>es bec<br>2 sho  | Completed            |  |   |                                  |  |                                      |  | 24a. Wa                              | s an                  | 24b. Were au                          | topsy findings available            |
| <u> </u>                        | en: The lar<br>tificate hes<br>or, page 2  | Соп                  |  |   |                                  |  |                                      |  | 12 Yes                               | ormed?                | death?                                | 2 No                                |
| Vita                            | nysicien: Th<br>nis certificate<br>director, pag   | Be c                 | 25. Was case referred to medical examiner? 1 X Yes 2 □ No                        | Hospital:   | 40-                              | ER/Outpatient  | 077.00.                              | 26. Place of Dea                               |                                      |                       |                                       |                                     |
| 0                               | ding Phys<br>h.<br>After this<br>funeral di  | n: To                | 27. Manner of Death  | 28a. Date of Inju<br>(Month, Day                                  |                                  | 28b. Time of<br>Injury   | 28c. In                              | 4   Nursing H                                  | 28d. Describe                        |                       | 6 □Other (Specury occurred            | cify)                               |
| sior                            | ttending I<br>death.<br>tor: After<br>the funer  | catlo                | 1  | n   |                                  |  | M 1                                  | Yes 2 No                                       |                                      |                       |                                       |                                     |
| Division of Vital Records, P.O. | Hospitel or Attending Physicien: The law requires that the death certificate be executed 24 hours after death. Funerel Director: After this certificate has been signed by the ettending physicien and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Certification:       | 4  Homicide determined   |   | ury - At ho<br>c. <i>(Specif</i> | ome, farm, stre<br>y)  | et, factory, offic                   | ee ·   | 28f. Location<br>City or To          | (Street a<br>wn, Stat | nd Number or Ru<br>'e)                | ıral Route Number,                  |
|                                 | To the Hospitel or Att<br>within 24 hours after de<br>To the Funerel Direct<br>completely filled in by t   | edical               | 29a. Certifier (Check only one)  | nysicien: To the best<br>niner: On the basis of<br>and manner sta | examina                          | wledge, death<br>tion and/or inv   | occurred at the<br>estigation, in my | time, date and place<br>y opinion, death occu  | , and due to the<br>rred at the time | cause(s<br>, date an  | s) and manner as<br>nd place, and due | stated.<br>to the cause(s)          |
|                                 | To the within To the comp  | W                    | 29b. Signature and title of certifier  | • •   | 200                              |  | 29c. Lice                            | nse number                                     |                                      | 29d. Da               | ate signed (Monti                     | h. Day, Year)                       |
|                                 |  |                      | Hati Che   | mila- To  | Ille                             | elis   | OCME                                 |  |                                      | Dec                   | ember 22                              | , 2005                              |
|                                 |  |                      | 30 Name and address of person who  | completed eguse of d  | eath (Iten                       | n 23a) (Type, F  |                                      | n Street I                                     | Baltimo                              | re M                  | aryland                               | 21201                               |
|                                 | Sta  |                      | 31. Date filed (Month, Day, Year)  | 32. Redistra  | ar's Signa                       |  | 1                                    |  |                                      |                       | <i>y</i> =                            |                                     |
|                                 | Registr  | ar                   | DEC 2 7  | 2005  |                                  | Nº A   |                                      |  |                                      |                       |                                       |                                     |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 22 MURIEL C. WILLIAMS 2005 4:00AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 32646 HIDDEN ACRES ROAD CORDOVA TALBOT If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) NOV 5 1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F 84 MARYLAND 219-05-9600 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Directo MD TALBOT CORDOVA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32646 HIDDEN ACRES ROAD 21625 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE þ 3 Widowed 4 □ Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 0 HOMEMAKER OWN HOME other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Importent: If item 27 is marked oth
any injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Sumame) Be CLARENCE WILLIAM WOOTERS ANITA EBERHARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA W. BLIZZARD/DAUGHTER 32705 REESES LANDING ROAD, CORDOVA, MD 21625 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State \* 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 12/27/2005 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 SHOL 7 MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) theurson of Thoracie Aorta Physician year /Medical Examiner evoscleusis eas Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a nonsequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐ Pregnant at time of death 5 Other (specify) <u>О</u>. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☑ No Division of Vital 2 ₽No Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After t 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Musell a. Siley St. H42587 12-22-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Cynwood Av Easton md 21601 Kussell A Schilling DO 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 23 Registrar

|                          |  |                   | 1- For State of Maryland Registrar  |                     |                                    | f Health ar<br>of Death                 | nd Menta         | l Hygie<br>Reg.            | ZUU              | 15                        | 42442                                     |
|--------------------------|--|-------------------|---|---------------------|------------------------------------|---|------------------|----------------------------|------------------|---------------------------|---|
|                          | Physic   | ian               | 1. Decedent's Name (First, Middle, Last)  |                     |                                    |   | 2. Dat           | e of Death                 | Day              | Year                      | 3. Time of Death                          |
|                          | /Medi  |                   | Howard Wilson Warrington Sr.  |                     |                                    |   | 12               |                            | 17               | 05                        | 10:40 A M                                 |
| 4                        | Exami  | ner               | 4a. Facility Name (If not institution, give street and number)  |                     | 4b. City, Tow                      | m, or Location of                       | Death            | ļ                          | 4c. County       | of Death                  |   |
|                          |  |                   | 12761 Richland Lane   |                     | Cord                               |   |                  |                            | Ta1              | bot                       |   |
|                          | Funeral<br>Director  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. las  | t birthday)<br>Yrs. | If Under 1 Yo<br>Months Da         |   | Min. (Mo         | e of Birth<br>nth, Day, Ye |                  |                           | place (State or Foreign                   |
|                          |  |                   | Usuel Residence of Decedent   | 173.                |                                    |   | 05-              | 17-19                      | 34               | _Mary                     | 1and                                      |
|                          | yland<br>yland   |                   | 10a. State 10b. County 10c. City, 1   | rown or Lo          | cation                             |   |                  |                            |                  | 1                         | Od. Inside City Limits                    |
|                          | Mar.   | ţō                | MD Talbot (   | Cordo               | v a                                |   |                  |                            |                  |                           | 1 ☐ Yes 21 No                             |
|                          | h the<br>or 284  | Funeral Director  | 10e. Street and Number  |                     | 10f. Zip Cod                       | ie                                      |                  | 10g.                       | Citizen of \     | What Cour                 | ntry?                                     |
|                          | th wil   | aD                | 12761 Richland Lane   |                     | 216                                | 25                                      |                  |                            | T                | ISA                       |   |
|                          | dea  | ner               | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  | 13. V               | Vas Decedent                       | of Hispanic Origin                      | ? (Specify Ye    | s or No-                   | 14. Rac          | e - Americ                |   |
| 9                        | or it  | F                 | 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No  | ŀ                   | Yes 2X                             | Suban, Mexican, f<br>No <i>Specify:</i> | ruento Hican, e  | HC.)                       |                  | k, White,                 |   |
| 8                        | d within 72 hours after death with the Maryland jiene.<br>rithen "naturel", or items 23a or 28a-f show the Modical Examinar must be notified at  | d by              | 3 Wildowed 4 Divorced Year or Dates:  |                     |                                    |   |                  |                            | Specify          | :Whit                     | e   |
| 5                        | "nat   | Completed         | 15. Decedent's Education (Specify only highest grade completed)   | (Give               | lent's Usual Oc<br>kind of work do | ne durina most o                        | f working        | 16b                        | . Kind of Bu     | usiness/Ind               | dustry                                    |
| 7                        | within<br>ene.<br>then "   | E G               | Elementary/Secondary (0-12)   |                     | OO NOT use re                      | · ·                                     |                  |                            |                  |                           | _   |
| 9                        | it is is   |                   | 17. Father's Name (First, Middle, Last)   |                     | Contrac                            |   | Name (First,     | Middle Mais                |                  | truct                     | tion                                      |
| an                       | d be<br>ental<br>ked c   | To Be             | Wilson Warrington   |                     |                                    |   |                  |                            |                  |                           |   |
| Maryland 21215-0036      | 2 should be and Mental I is marked o   | -                 |   | 19b. Mailin         | a Address (Str                     | eet and Number of                       | salie S          |                            |                  |                           | Codel                                     |
|                          | and 2<br>lealth a<br>m 27 is   |                   | Dan W. Warrington / Son   |                     |                                    |   |                  |                            |                  |                           |   |
| re,                      | - T A =  | 1 3               | 20a. Method of Disposition 20b. Place   | e of Dispos         | sition (Name of                    | hoe Rive                                | r Koad<br>Date   |                            | On M             |                           |   |
| E O                      | Pages<br>nent of I<br>ant: if Ita  |                   | L M Durial 2 Coloniation 3 Chemioval num State  |                     | ill Com                            | etery 1                                 | 2/21/20          |                            |                  |                           |   |
| Baltimore,               | 교육변경 .   |                   | 21. Signature of Funeral Service Licensee   |                     |                                    |   |                  |                            | aston            |                           |   |
| m                        | Dermi<br>Depa<br>Impo<br>any ii  |                   | JUHN R MERIERED   | Fe                  | ellows,                            | Helfenb<br>arrison                      | ein and          | l Newn                     | am Fu            | neral                     | Home, PA                                  |
|                          | 9  |                   | 23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. | Do not ente         | r the mode of                      | dying, such as ca                       | rdiac or respira | tory arrest,               | OII, M           | D ZIC                     | Approximate                               |
| W                        | Priysician   |                   | Immediate Cause (Final disease or condition   | 17 /                | 400 -                              | - 0.11                                  |                  |                            |                  |                           | Interval Between<br>Onset and Death       |
|                          | /Medical   |                   | resulting in death)  a  Due to (or a n consequence)   | ce of):             | / V/V/                             | Puil.                                   | 1/6              |                            |                  | Se                        | was heard                                 |
|                          | Examiner   |                   | Sequentially list conditions b.   |                     |                                    |   |                  |                            |                  |                           |   |
|                          | D #  | iner              | Sequentially list conditions, if any, leading to immediate cause. Chief Underlyling Cause (Disease or injury                        | ce of):             |                                    |   |                  |                            |                  |                           |   |
|                          | ecute<br>and<br>-trans   | Examiner          | that initiated events  c.   |                     |                                    |   |                  |                            |                  |                           |   |
| 8760,                    | cate be executed<br>physicien and<br>the burial-transit  |                   | Due to (or as a consequent  | ce of):             |                                    |   |                  |                            |                  |                           |   |
| 87                       | phys<br>the  | Physiclan/Medical | d   |                     |                                    |   |                  |                            |                  |                           |   |
| 9 X                      | certifi<br>ding<br>se as   | /Me               | IF FEMALE: 23c. If yes, outcome of pregnancy  | ***                 |                                    |   |                  |                            |                  |                           |   |
| Вох                      | atten<br>for u   | clan              | in the past 12 months?  | ath 3 □             | Ectopic pregna<br>Other (specify)  |   |                  |                            | 23d. Date<br>Mor | of deliver                | y<br>Day Year                             |
| o.                       | that the death certific<br>ed by the attending p<br>detached for use as:   | ıysi              | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown  | 3                   | Other (specify)                    |   |                  |                            |                  |                           |   |
| <b>a</b>                 | res that<br>igned b  | y P               | Part II. Other significant conditions contributing to death but not resulting   | g in the un         | derlying cause                     | given in Part I.                        | 23e              | Did tobacci                | use contri       | bute to the               | eduse of death?                           |
| rds,                     | The law requires that the death certific<br>tie has been signed by the attending p<br>bage 2 should be detached for use as   | d by              |   |                     |                                    |   |                  | 1 🗆 Yes                    |                  |                           | bly 4 □Unknown                            |
| 00                       | w require<br>s been sign<br>should b   | Completed         |   |                     |                                    |   | 242              | Was an                     | 24b VA           | loro outon                | au findiana austable                      |
| Re                       | Physicien: The law<br>r this certificate has b<br>aral director, page 2 s  | duc               |   |                     |                                    |   | -   240.         | autopsy<br>performed?      | p                | rior to comeath?          | sy findings available pletion of cause of |
| ā                        | en: ]<br>tificat<br>tor. p   | a                 | 25. Was case referred to medical  |                     |                                    | 00 Di                                   |                  | Yes 201                    | 10 1             | ☐ Yes 2                   | 2 A No                                    |
| <u> </u>                 | ysici<br>s cer<br>direct   | To B              | examiner?   | Outnationt          | 3□ DOA I                           | Other: 4 Nursin                         | Death (Check     |                            | 0                |                           |   |
| 0                        | Attending Physicien: r death. ector: After this certifica by the funeral director.   | Ę                 | 27. Manner of Death 28a. Date of Injury 28t   | . Time of           | 28c. In                            | lury at                                 | 28d. Des         | cribe how in               | ury occurre      | r ( <i>Specify)</i><br>ed |   |
| Ö                        | ath.<br>r: Af  | atle              | 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation  | Injury              |                                    | Yes 2 □ No                              |                  |                            |                  |                           |   |
| Division of Vital Record | or Attending Phy<br>after death.<br>I Director: After this<br>d in by the funeral d  | Certification;    | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)                                    | farm, stree         | et, factory, offic                 | e                                       | 28f. Loca        | tion (Street               | and Numbe        | r or Rural                | Route Number,                             |
|                          | telo<br>rs aft<br>el Di  | Cer               | building, std. (oposity)  |                     |                                    |   | Chy              | or Town, Sta               | ie)              |                           |   |
|                          | To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in by   | edical            | 29a. Certifier (Check only one) Medical Examiner: On the basis of my knowled and mannes stated and mannes stated.                   | lge, death          | occurred at the                    | time, date and pl                       | ace, and due t   | o the cause(               | s) and man       | ner as sta                | ted.                                      |
|                          | the hin 2 the hi | Med               | and masses lated.   |                     |                                    |   | Coursed at the   |                            |                  |                           |   |
|                          | To To  |                   | 29b. Signature and title of certifier   |                     | 29c. Lice                          | nse number                              | _                | 29d. D                     | ate signed       |                           |   |
|                          |  |                   | of many ( Charton)  | m                   | 12                                 | 3/466                                   |                  | /                          | 2/19             | 1/05                      |   |
| +1                       | VA   |                   | 30. Name and address of person who completed cause of death (Item 23a   |                     | •                                  |   |                  |                            | -                |                           |   |
|                          | Sta  |                   | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | utchm               | ans Lai                            | ne, East                                | on, MD           | 21601                      |                  |                           |   |
|                          | Registra   |                   | 31. Date filed (Month, Day, Year) DEC 1 9 2805  | San                 |                                    |   |                  |                            |                  |                           |   |
|                          |  |                   |   | S. C. C.            |                                    |   |                  |                            |                  |                           |   |

|            |   | _ 1            | For State Registrer  | te of Maryland /   |                         | artment<br>tificate          |                              |                    | ınd M                   |                                | giene<br>Reg. No. ()                  | 05           | 42443  |
|------------|---|----------------|--|--|-------------------------|------------------------------|------------------------------|--------------------|-------------------------|--------------------------------|---------------------------------------|--------------|--|
|            | Pr V  |                | Decedent's Name (First, Middle, Last)  |  |                         |                              |                              |                    |                         | 2. Date of De.<br>Month        | ath<br>Day                            | Year         | 3. Time of Death                                 |
|            | Physicia<br>/Medic  | Sec. 1         | Daisy 6. Who   | len  |                         |                              |                              |                    |                         | Decemb                         |                                       | 2005         | 8:27 A M   |
| 1          | Examin  | _              | 4a. Facility Name (If not institution, give street                                 |  |                         | 4b. City, T                  |                              | Location o         | f Death                 |                                |                                       | ty of Death  |  |
| 4 3        |   | 1 4 2 mg       | Montgomery General   |  | to look of a col        | Olne                         | _                            | If Under           | 24 Hrs                  | 8. Date of Birt                |                                       | ontgo        | 4  |
|            | Funeral<br>Director   |                | 5. Social Security Number 6. Sex 1 ☐ M 2   | 7. Age (In yrs. last                                       | Yrs.                    |                              | Days                         | Hours              | Min.                    | (Month, Da                     | у, <sub>Year)</sub><br>5 <b>19</b> 22 |              | nplace (State or Foreign<br>untry)<br>anama      |
| 495        |   |                | Usual Residence of Decedent  |  |                         |                              |                              |                    |                         |                                |                                       |              |  |
|            | how   |                | 10a. State 10b. County   | 10c. City, To  |                         | cation                       |                              |                    |                         |                                |                                       |              | 10d. Inside City Limits 1 Yes 2 No               |
|            | Be-f e  | Director       | Md. Montgomer  | y Oln  | ey                      | 1.2                          |                              |                    |                         |                                | 10a Citizan a                         | f What Co    |  |
|            | J within 72 hours after death with the Maryland<br>jiele.<br>r than "natural", or Iteme 23s or 28s-f ehow<br>the Medical Examination must be notified at                                      | Dire           | 10e. Street and Number<br>18211 Allwood Terra                                      | ce   |                         | 10f. Zip (                   | Code                         | 208                | 3 <b>3</b> 2            |                                | 10g. Citizen o                        | ed St        |  |
|            | eath v  | erai           |  | as Decedent Ever in U.S.                                   | 13. \                   | Was Decede                   | ent of His                   | spanic Orig        | gin? (Spe               | cify Yes or No                 |                                       | ace - Amer   | rican Indian,                                    |
|            | ter de  | Funerai        | 1 Never Married 2V Married 10  | ned Forces?  |                         |                              |                              |                    |                         | cify Yes or No<br>Rican, etc.) |                                       | lack, White  |  |
| 21215-0036 | al', o  | þ              | 3 ☐ Widowed 4 ☐ Divorced Ye  | es, Give<br>ar or Dates:                                   |                         | 1XYes 2                      | □ No                         | Ѕреспу:            | Pan                     | amania:                        | n Spec                                | ity: WI      | nite<br>   |
| 5-0        | 72 ho   | Completed      | 15. Decedent's Education (Specify only highest grade com                           |  | (Give                   | dent's Usual<br>kind of work | k done d                     | u <i>rina</i> mosi | t of workii             | ng                             | 16b. Kind of                          | Business/1   | ndustry  |
| 21         | within ene.   | Jd I           | Elementary/Secondary (0-12)  | llege (1-4or 5+)   |                         | okkeep                       |                              |                    |                         |                                | Railr                                 | coad (       | Company  |
| 12         | il Hygier<br>other th   |                | 12   17. Father's Name (First, Middle, Last)                                       | 4  |                         |                              | -                            | 18. Mothe          | ar's Name               | (First, Middle,                | , Maiden Sumi                         | ame)         |  |
| Maryland   | d la b  | To Be          | Francisco Galleg   | os   |                         |                              |                              | Ma                 | arta                    | Ver                            | nal                                   |              |  |
| 37         | 2 should be<br>and Mental<br>le marked<br>aumatic ev  | F              | 19a. Informant's Name/Relationship (Type, Pr                                       |  |                         |                              |                              |                    |                         |                                | er, City or Tow                       |              |  |
|            | 1 and 2 s<br>Heelth an<br>tem 27 le i   |                | Charles T. Whalen /  | Husband  | 182                     | 11 Al                        | lwoo                         | d Ter              |                         |                                |                                       |              | 0832   |
| ore,       | of Hee  |                | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov                     | come   | of Dispo<br>etery, crea | sition (Nam<br>matory or oth | e of<br>her place            | 9)                 |                         | ate                            | 20c. Location                         |              |  |
| Ë          | Pages<br>ment of h<br>ant: If it  |                | 4 □Donation 5 □ Other (Specify)  | Gate   |                         | Heave                        |                              |                    |                         | .6/05                          | Silver                                | : Spr        | ing, Md.   |
| Baltimore, | permit. Page<br>Department of<br>Important: If<br>eny Injury  |                | 21. Signature of Funeral Service Licensee  | 1  | 22                      |                              | el H                         | . Baı              | rber                    | Funera                         |                                       |              |  |
|            | ⊈ ⊕ a   |                | 23a. Part1. Enter the disease, or complication                                     | s that caused the death. [                                 | not en                  | P. O                         | B of dvino                   | ox 50              | 038,                    | Layton                         | sville,                               | Md.          | 20882<br>Approximate                             |
|            |   |                | shock, or heart failure. List only one cau<br>Immediate Cause (Final               | se on each line.   |                         |                              |                              |                    | 0410100                 | . Toophiatory a                |                                       |              | Interval Between<br>Onset and Death              |
|            | Physician /Medical  |                | disease or condition a   | RESPITOLD  Due to (or as a consequent                      |                         | 100                          | ilu                          | ve.                |                         |                                |                                       |              | 10 years   |
| E          | Examiner  |                |  | Chursic (  | ) he                    | tractor                      | P.                           | Palm               | worker                  | ry Di                          | SPUAD                                 |              | ,  |
| ٧.         |   | je.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequen                                  | ce of):                 | 70011                        |                              | 0001               | -0 101                  |                                | BCW                                   |              |  |
|            | cuted<br>nd<br>ransit   | Examiner       | that initiated events c  |  |                         |                              |                              |                    |                         |                                |                                       |              |  |
| 0,         | e exe<br>sian er<br>urial-t   | Ex             | resulting in death) Last   | Due to (or as a consequen                                  | ce of):                 |                              |                              |                    |                         |                                |                                       |              |  |
| 8760       | death certificate be executed e attending physician end of for use as the burial-transit  | dicai          | d  |  |                         |                              |                              |                    |                         |                                |                                       |              |  |
| x 68       | ding p  | Physician/Med  | IF FEMALE: 23c. If   | yes, outcome of pregnancy                                  | ,                       |                              |                              |                    |                         |                                | 23d. [                                | Date of deli | iverv  |
| Box        | atten<br>for u  | cian           | 23b. Was decedent pregnant   | Live birth 2 Fetal de                                      | ath 3                   | □Ectopic pre □ Other (spe    |                              |                    |                         |                                |                                       | Month        | Day Year   |
| o.         | 0 0   | ysi            | 9 Unknown 9  | Unknown  |                         |                              |                              |                    |                         |                                |                                       |              |  |
| 0          | The law requires that the death cer<br>ate has been signed by the attendir<br>page 2 should be detached for use   | by PI          | Part II. Other significant conditions contribut                                    | ing to death but not resulting                             | ng in the u             | ınderlying ca                | ause give                    | en in Part I       |                         | 23e. Did                       | tobacco use co                        | ontribute to | the cause of death?                              |
| rds        | w require<br>been sig<br>should b   | ed b           | Aspiration Dr  | eumon)   | 0                       |                              | ,                            |                    | _                       | 10                             | Yes 2□No                              | 3 □ Pr       | obably 4 SUnknown                                |
| Records,   | aw requ   | Completed      | Methicillin Rosistant  | Staph Au   | KU                      | SS                           | epsi                         | 5_                 |                         | 24a. Was                       | an 24l                                | o. Were au   | itopsy findings available completion of cause of |
| Ä          |   | E              | Sacral Decuk   | oi + i   |                         |                              | /                            |                    |                         | perfe<br>1 ☐ Yes               | 2 No                                  | death?       | 2□ No  |
| Vital      | lcian: Th<br>certificate<br>rector, pag   | Be             | 25. Was case referred to medical examiner?   | -1.  |                         |                              | 0#                           |                    | e of Death              | (Check only                    | one)                                  |              |  |
| of \       | hysic<br>this c   | ို             | 1 Yes 2 No   | inpatient 20 Er  | VOutpatie               |                              |                              | 4 📋 INI            |                         |                                | how injury occ                        |              | cify)  |
| u C        | Alter<br>funer  | ion            | 1 SaNatural 5 ☐ Pending  | a. Date of Injury 28<br>(Month, Day Year)                  | Injury                  | M                            | 8c. Injury<br>World<br>1 ☐ 1 | k?<br>Yes 2□       |                         | 200. 000000                    | non anjanj ees                        |              |  |
| Division   | death<br>death<br>ctor:<br>y the  | ficat          | 3 Suicide 6 Could not be 28  | e. Ptace of Injury - At home                               | ə, farm, st             |                              |                              |                    |                         |                                |                                       | mber or Ri   | ural Route Number,                               |
| Θ          | after after Dire  | Certification: | 4 Homicide   | building, etc. (Specify)                                   |                         |                              |                              |                    |                         | City or 10                     | wn, State)                            |              |  |
|            | ospita<br>hours<br>unera  | caic           | 29a. Certifier  (Check only 2 Medical Examiner:                                    | : To the best of my knowled<br>on the basis of examination | edge, dear              | th occurred a                | at the tim                   | ne, date ar        | nd place,<br>ath occurr | and due to the                 | cause(s) and<br>date and place        | manner as    | s stated.<br>e to the cause(s)                   |
|            | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification in the funeral director; completely filled in by the funeral director, | Aedicai        | one)   | nd manner stated.  |                         |                              |                              | e number           |                         |                                | 29d. Date sig                         |              |  |
|            | T V With  | Σ              | 29b. Signature and title of contifier  | <i>a</i>   |                         | 290                          | / 'D                         | - Humber           | 0                       |                                | 121                                   | 2).          |  |
|            | 4   |                | Simo   | (mys)cia)  | 7<br>20) (T:===         | Print\                       | 60                           | 16                 | 0                       |                                |                                       | 210          | 5  |
|            | i   |                | 30. Name and address of person who comple  | ed cause of death (item 2                                  | 34) (Type<br>1810       | )1 Pri                       | nce                          | Phil               | ip D                    | rive, C                        | Olney,                                | Md.          | 20832  |
| .03        | ्र वर्षे १ <b>८</b> ।   | ate            | 31. Date filed (Month, Day, Year)  | 3. Registrar's Signatur                                    |                         | ule                          |                              |                    |                         |                                |                                       |              |  |
|            | Regist  |                | DFC 15 2005  | Same S.  | 1930                    |                              |                              |                    |                         |                                |                                       |              |  |

|                            |   |                | 1 - For<br>State<br>Registrar   |                        | State of I                                | Marylar       |                                 | artmen<br>rtificat       |                          |                           |                          | lental Hy                       | gien     | 211115                               | 42                        | l, l, l,       |
|----------------------------|---|----------------|---|------------------------|---|---------------|---------------------------------|--------------------------|--------------------------|---------------------------|--------------------------|---------------------------------|----------|--------------------------------------|---------------------------|----------------|
|                            | Dhysis  | 2.             | 1. Decedent's Name (First, Mid  | dle, Last)             |   |               |                                 |                          |                          |                           |                          | 2. Date of Di                   | ath      |                                      | 3. Time                   | of Death       |
|                            | Physic<br>/Medi   |                | Ivah Noral  |                        | Washab                                    |               |                                 |                          |                          |                           |                          |                                 |          | 12, 2005                             | 5:30                      | a M            |
|                            | Examir  | ier            | 4a. Facility Name (If not instituti   |                        | reet and numbe                            | er)           |                                 |                          |                          | Location                  |                          |                                 |          | c. County of Dea                     |                           |                |
|                            |   | 943            | 5019 Berwyn R 5. Social Security Number   | 6. Sex                 | 7   | A== (l==      | to a thint to 1                 | Co1                      |                          | Par<br>If Under           |                          |                                 |          | Prince (                             |                           |                |
|                            | - Funeral Director  |                | 448-07-0482   | 1                      | M 2 📉                                     |               | last birthday)<br>88 Yrs.       | Months                   |                          | Hours                     | Min.                     | 8. Date of Bi<br>(Month, Di     |          |                                      | thplace (State<br>ountry) | or Foreign     |
| 1 %                        | D   |                | Usual Residence of Decedent   |                        |   |               | 00                              |                          |                          |                           |                          | Dec. 2                          | 0, _     | 1916 C                               | klahom                    | a              |
|                            | rylan   |                | 10a. State 10b. Coun  | ty                     |   | 10c. Cit      | ty, Town or Lo                  | cation                   |                          |                           |                          |                                 |          |                                      | 10d. Inside               | City Limits    |
|                            | e Ma  | cto            | Maryland Princ  | ce Ge                  | orge's                                    | Co            | llege 1                         | Park                     |                          |                           |                          |                                 |          |                                      | 1 🔯 Y∈                    | s 2 No         |
|                            | or 2  | Director       | 10e. Street and Number  |                        |   |               |                                 | 10f. Zip                 | Code                     |                           |                          |                                 | 10g. C   | itizen of What C                     | ountry?                   |                |
|                            | within 72 hours after death with the Maryland<br>sne.<br>than "natural, or iteme 23s or 28e-f show<br>its Medical Examiner must be invitified at  |                | 5019 Berwyn Ro  |                        |   |               |                                 |                          | 0740                     |                           |                          |                                 |          | USA                                  |                           |                |
|                            | item<br>item  | Funeral        | 11. Marital Status  1 Never Married 2 Ma  |                        | 2. Was Decede<br>Armed Force<br>1 Yes 2 [ | s?            | .S. 13.                         | Was Deced<br>f Yes, spec | ent of Hi                | spanic Ori<br>n, Mexicar  | igin? (Spe<br>n, Puerto  | ecify Yes or No<br>Rican, etc.) | )-       | 14. Race - Am<br>Black, Whi          |                           |                |
| 336                        | urs af  | þ              | 3 X Widowed 4 □ Divorce   |                        | If Yes, Give<br>Year or Date:             | _             |                                 | 1 🗌 Yes                  | 2 🔀 No                   | Specify:                  |                          |                                 |          | SpecifyWhi                           | te                        |                |
| 0-10                       | 2 ho  | Completed      | 15. Decede  | ent's Educa            | ation                                     |               | 16a. Deced                      | dent's Usua              | al Occupa                | ition                     |                          |                                 | 16b.     | Kind of Business                     | /Industry                 |                |
| 215                        | thin 7<br>8.  | ple            | (Specify only high<br>Elementary/Secondary (0-12)   |                        | College (1-4c                             | or 5+)        | (Give                           | kind of wo<br>DO NOT us  | rk done d<br>se retired, | lu <i>ring m</i> os       | st of worki              | ng                              |          |                                      | ,                         |                |
| 2                          | ge wil  | 50             | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |                        | 4   |               | Admir                           | nistra                   | ative                    | e Ass                     | ista                     | nt                              | Uni      | versity                              | of Ma:                    | ryland         |
| nd                         | be file<br>tal Hy<br>d oth  | Be             | 17. Father's Name (First, Middle  |                        |   |               |                                 |                          |                          | 18. Mothe                 | er's Name                | (First, Middle                  | , Maide  | n Sumame)                            |                           |                |
| yla                        | ould<br>Men<br>mrke   | မ              | Walter M. Sa  |                        |   |               |                                 |                          |                          |                           | G.                       |                                 |          |                                      |                           |                |
| Maryland 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28e -f ehow any injury of pher traumatic event, the Medical Examination at the positive and once. |                | 19a. Informant's Name/Relation<br>Diane W. Washa  |                        |   | hter          | 19b. Mailin                     | Address                  | (Street a                | nd Numbe                  | er or Rura               | I Route Numb                    | er, City | or Town, State,                      | Zip Code)                 |                |
| e,                         | 1 and<br>Health   |                |   |                        | 1, Daugi                                  |               | Place of Dispo                  |                          |                          |                           |                          |                                 |          | r Sprin                              |                           | )904<br>       |
| Baltimore,                 | 8 5 ± 30  |                | 20a. Method of Disposition 1 Description 2 Surplementation  |                        | moval from Stat                           | le C          | emetery, cren                   | natory or o              | ther place               | ,                         | ecemb                    |                                 |          | Location - City or                   |                           |                |
| Ħ                          | it. Part  |                | 4 Donation 5 Other (  |                        |   | Met           | ropolita                        |                          |                          | 1                         | 200                      |                                 |          | xandria                              | , Virgi                   | inia           |
| Ba                         | Depa<br>Impo<br>any i   |                | Bow 7   | S ricensee             | 0.  |               | Fr                              | ancis                    | a Addres                 | coll                      | ins :                    | Funeral                         | Но       | me Inc<br>r Sprind                   |                           |                |
|                            | *   |                | 23a. Part1. Enter the disease,  | or complica            | itions that caus                          | ed the death  |                                 |                          |                          |                           |                          |                                 |          | r spring                             | Approxima                 | 20901          |
|                            | Physician   |                | Immediate Cause (Final  | it only one            | Atheros                                   | line.         |                                 |                          |                          |                           |                          |                                 |          |                                      | Interval Be<br>Onset and  | tween<br>Death |
| Seg."                      | /Medical  |                | disease or condition<br>resulting in death)   | a                      |   | is a consequ  |                                 | ratov                    | ascu                     | liar                      | Disea                    | ase                             |          |                                      | 15 Ye                     | ears           |
| À                          | Examiner  |                | O   |                        | ,   | ,             |                                 |                          |                          |                           |                          |                                 |          |                                      |                           |                |
| Ь.                         | D =   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | J b                    | Due to (or a                              | is a consequ  | uence of):                      |                          |                          |                           |                          |                                 |          |                                      |                           |                |
|                            | ocuter<br>nd<br>trans   | am             | triat initiated events  | ) c                    |   |               |                                 |                          |                          |                           |                          |                                 |          |                                      |                           |                |
| 0,                         | ate be executed<br>hysician and<br>the burial-transit   | dical Examine  | resulting in death) Last  |                        | Due to (or a                              | is a consequ  | uence of):                      |                          |                          |                           |                          |                                 |          |                                      |                           |                |
| 8760,                      | ficate be executed<br>physician and<br>is the burial-transit  | dlca           |   | d. ,                   |   |               |                                 |                          |                          |                           |                          |                                 |          |                                      |                           |                |
| 9<br>×                     | leath certific<br>attending p   | Physiclan/Med  | IF FEMALE:  | 22-                    | 16  |               |                                 |                          |                          |                           |                          |                                 |          |                                      |                           |                |
| Вох                        | atten<br>for us   | lan            | 23b. Was decedent pregnant in the past 12 months?   | 230                    | If yes, outcom                            | 2 Fetal       | death 3                         | Ectopic pre              |                          |                           |                          |                                 |          | 23d. Date of del<br>Month            | ivery<br>Day              | Year           |
| o.                         | the de  | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                        | 4□Pregnant<br>9□Unknown                   | at time of de | eath 5                          | Other (spe               | ecify)                   |                           |                          |                                 |          | World                                | Day                       | 1 021          |
| ٦.                         | law requires that the death certific<br>as been signed by the attending p<br>2 should be detached for use as  |                | Part II. Other significant condit   | ions contri            | buting to death                           | but not resu  | ulting in the un                | derlying ca              | use give                 | n in Part I.              |                          | 23e, Did to                     | obacco   | use contribute to                    | the cause of              | death?         |
| ds                         | uires<br>sign   | Ω              | Alzheimer's D   |                        |   |               |                                 | , ,                      |                          |                           |                          |                                 |          | Ma Sarah                             |                           |                |
| Ö                          | w require<br>been signature   | Completed      |   |                        |   |               |                                 |                          |                          |                           |                          | 24a. Was                        |          | 24h Word av                          | to-out tindings           |                |
| æ                          | 9 4 9   | mc             |   |                        |   |               |                                 |                          |                          |                           |                          | autop                           |          | 24b. Were au<br>prior to death?      | completion of             | cause of       |
| ta                         | sician: Th<br>certificate<br>rector, pag  | a)             | 25. Was case referred to medical  | al                     |   |               |                                 |                          |                          | 00 Di                     | -4 D - 45                | 1 Yes                           |          | 1 ☐ Yes                              | 2 🗌 No                    |                |
| <u> </u>                   | w 5   | ToB            | examiner?<br>1 ☐ Yes 2 <b>% X</b> No  |                        | spital:                                   | tient 2 🗆     | ER/Outpatient                   | 3 DO                     | Other                    | _                         |                          | (Check only o                   |          | 6 ☐Other (Spec                       |                           |                |
| 0                          | g Ph<br>ter th  |                | 27. Manner of Death   |                        | 28a. Date of In<br>(Month, D              | jury          | 28b. Time of                    |                          | c. Injury<br>Work        |                           |                          | 8d. Describe h                  |          |                                      | any)                      |                |
| 0                          | uttendir<br>death.<br>ctor: Af<br>y the fur   | atic           |   | tigation               | (111011111, 2                             | ay /oa/)      | Injury                          | М                        |                          | es 2 1                    | No                       |                                 |          |                                      |                           |                |
| Division of Vital Records, | after death. Director: After a in by the funera   | Certification; | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide deter   | not be<br>mined        | 28e. Place of In                          | njury - At ho | me, farm, stre                  | et, factory,             | office                   |                           | 2                        | 8f. Location (S<br>City or Tou  | treet al | nd Number or Ru                      | ral Route Nur             | nber,          |
|                            |   |                |   |                        |   |               |                                 |                          |                          |                           |                          |                                 |          |                                      |                           |                |
|                            | e Hospital of 124 hours at Euneral Dietely filled i   | edical         | 29a. Certifier (Check only one) Certifyi  | ng Physic<br>I Examine | . On the basis                            | or examinar   | wledge, death<br>ion and/or inv | occurred a estigation,   | it the time<br>in my opi | e, date and<br>nion, deat | d place, a<br>th occurre | nd due to the d                 | ause(s   | and manner as<br>d place, and due    | stated.<br>to the cause(  | s)             |
|                            | To the within 2 To the complet  | Med            | 29b. Signature and title of pertific  |                        | and mapper s                              | stated.       |                                 |                          | License                  |                           |                          |                                 |          |                                      |                           |                |
| )                          | + 3 F 8   |                |   | wh                     | MBV                                       | WW            |                                 |                          | D315                     |                           |                          |                                 |          | ite signed <i>(Montl</i><br>ember 12 |                           |                |
| (                          | 8   | -              | 30. Name and address of person  | who com-               | oleted cause of                           | death (line   | 239) /T 7                       |                          |                          |                           |                          |                                 | Jec 6    | mper 12                              | , 2005                    |                |
|                            |   |                | Charles W. Ben  |                        |   |               |                                 | ,                        | rivo                     | Q:1                       | W.C.**                   | Snni                            | B# =     | 20901                                |                           |                |
| . 6                        | Sta   | e              | 31. Date filed (Month, Day, Year  | )                      | orden :                                   |               |                                 |                          | - 1 1 6                  | , 011                     | rver_                    | obr rud                         | , 141 L  | 7020I                                |                           |                |
| 17                         | Registra  | ar .           | DEC 15  | 2005                   | JAA                                       | U 15.         | ure Appe                        | W.                       |                          |                           |                          |                                 |          |                                      |                           |                |

|                |  |               | For State Registrar  | State of M   | laryland / Dep                           | ertificate of  |   |  | 200                         | 15                       | 42445                           |
|----------------|--|---------------|--|--|--|--|---|--|-----------------------------|--------------------------|---------------------------------|
| 272            | *  |               | Decedent's Name (First, Midd   | e, Last)   |  | 711770010 07   |   | 2. Date of Dea                         | Reg. No.                    |                          | 3. Time of Death                |
|                | Physic<br>/Med   |               | Geraldine  | Frances  | Waltha                                   | m  |   | Decembe                                | er 9, 20                    | )05                      | 9:48 a M                        |
|                | Exami  |               | 4a. Facility Name (If not institution  | n, give street and number                              | )  | 4b. City, Town, o                                      | or Location of Death                        |  | 4c. County                  |                          |                                 |
|                |  |               | 3407 Churchil  |  |  |  | Owings                                      |  |                             | alver                    | t                               |
| e.             | Funeral  |               | 5. Social Security Number  | 6. Sex 7. A  | ge (In yrs. last birthda)<br>Q G Yrs.    | Months Days  | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birt<br>(Month, Day         | y, Year)                    | 9. Birthp<br>Cour        | lace (State or Foreign          |
|                | Director   | 4             | 578-12-3272 Usual Residence of Decedent  |  | 85 Yrs.                                  |  |   | Oct. 2                                 | , 1920                      | Wash                     | ington, DC                      |
|                | show   |               | 10a. State 10b. County   |  | 10c. City, Town or I                     | ocation  |   |  |                             | 1                        | 0d. Inside City Limits          |
|                | the Mar<br>28a-f sl  | ctor          | MD Cal   | <i>r</i> ert   | Ow                                       | ings   |   |  |                             |                          | 1 ☐ Yes 2 📉 No                  |
|                | ith th<br>or 28  | Director      | 10e. Street and Number   |  |  | 10f. Zip Code  |   |  | 10g. Citizen of             | What Cour                | itry?                           |
|                | after death with the Maryland<br>or Items 23a or 28a-f show  |               | 3407 Churchill   |  |  | 2  | 0736  |  | U                           | .S.A.                    |                                 |
|                |  | Funerai       | 11. Marital Status   | 12. Was Decedent<br>Armed Forces                       | ?  | Was Decedent of H<br>If Yes, specify Cuba              | lispanic Origin? (Sp<br>an, Mexican, Puerto | pecify Yes or No-<br>Rican, etc.)      | 14. Rad<br>Bla              | e - Americ<br>ck, White, |                                 |
| 36             |  | by F          | 1 ☐ Never Married 2 ☐ Mar<br>3 🔀 Widowed 4 ☐ Divorced  | If Voc Cinco   | No                                       | 1 ☐ Yes 2X No  | Specify:                                    |  | Specif                      |                          | hite                            |
| 21215-0036     | "naturel", or Ite  | ted           | 15. Deceder  | t's Education  | 16a. Dec                                 | ident's Usual Occup                                    | pation                                      |  | 16b. Kind of B              |                          |                                 |
| 215            | within 7.<br>ene.<br>then "n   | Completed     | (Specify only highe<br>Elementary/Secondary (0-12)   | st grade completed)  College (1-4or                    | (Giv                                     | kind of work done<br>DO NOT use retired                | during most of work<br>d)                   | ang                                    | TOD. TAING OF D             | 03111033F1110            | Justry                          |
| 21             | gien<br>gien<br>er th  | Som           | 12   | College (1 40)   |  | ncial ana  | lyst  | ]                                      | Federal                     | Gove                     | rnment                          |
| pu             | be file<br>tal Hy<br>d oth   | Be (          | 17. Father's Name (First, Middle,  | Last)  |  |  | 18. Mother's Nam                            | e (First, Middle,                      | Maiden Suman                | ne)                      |                                 |
| <u>\</u>       | ould<br>Men<br>Parke   | ို            | Robert Henry   | Gerhardt   |  |  | Goldie                                      | Xina                                   | Lefev                       |                          |                                 |
| Maryland       | permit. Pages 1 and 2 should be filed within 72 ho<br>Department of Health and Mental Hygiene.<br>Important: If Item 27 is marked other than "natur<br>any njury or other traumatic event, tra Medical<br>DRG! | 10            | 19a. Informant's Name/Relations  |  |  | ng Address (Street                                     |   |  |                             |                          | Code)                           |
|                | 1 and<br>Healt<br>em 2<br>ther   |               | Sharon L. Bland 20a. Method of Disposition   | itord, daugh   | 20b. Place of Disp                       | Churchil   |   | Owings,                                |                             |                          |                                 |
| Baltimore,     | ages<br>nt of<br>nt of<br>nt of  | 1             | Murial 2 ☐ Cremation   |  | cemetery, cre                            | matory`or other plac                                   | ce)   |  | 20c. Location -             |                          |                                 |
| Ħ              | it. P.   |               | 4 ☐ Donation 5 ☐ Other (S  |  | Arlington                                | <ol> <li>Nationa.</li> <li>Name and Address</li> </ol> |   | 23,2005                                | Arlin                       | gton,                    | VA                              |
| Ba             | permit. Departrimporta   |               | Anya!  | Mulea  | Į.                                       | ausch Fund   | ,   | , P.A.,                                | Owings                      | , MD                     | 20736                           |
|                |  |               | 23a. Part1. Enter the disease, or<br>shock, or hear failure. List  | complications that caused<br>only one cause on each li | d the death. Do not en                   | ter the mode of dyin                                   | g, such as cardiac                          | or respiratory arr                     | rest,                       |                          | Approximate<br>Interval Between |
|                | Physician  |               | Immediate Caus Final disease or condition  | STR  | OKE                                      |  |   |  |                             |                          | Onset and Death                 |
|                | /Medical<br>Examiner   |               | resulting in death)  | Dy Cor as  | a consequence of):                       | 32334  | 1   | . 1                                    | 1                           | 0000                     |                                 |
|                | LAGITITIC  | <u></u>       | Sequentially list conditions   | b. Ather   | oscieros                                 | ic con   | ebrovas                                     | scular                                 | dis                         | eas                      | e                               |
|                | led<br>isit  | Examiner      | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as  | a consequence of):                       | lemia  |   |  |                             |                          |                                 |
| _6             | be execute<br>sician and<br>burial-trans   | хап           | that initiated events resulting in death) Last   | c. Due to (r s   | a conseque e of):                        | ema  |   |  |                             |                          |                                 |
| 8760,          | siciar<br>buria  | dicat E       |  |  | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,  |  |   |  |                             |                          |                                 |
| 9              | ificate<br>g physi<br>as the b   | edic          |  | d.   |  |  |   |  |                             |                          |                                 |
| Box            | death certific<br>attending p  | Physician/Me  | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome                                   |  |  |   |  | 23d Dat                     | e of delive              | ~                               |
|                | death  | icia          | in the past 12 months?   | 4☐Pregnant at  | 2 Fetal death 3 [ time of death 5 [      | Ectopic pregnancy Other (specify)                      |   |  | Mod                         |                          | Day Year                        |
| P.0            | that the de<br>led by the a<br>detached  | hys           | 9 Unknown  | 9□ Unknown   |  |  |   |  |                             |                          |                                 |
|                | 50 00  |               | Part II. Other significant condition   |  |  | derlying cause give                                    | en in Part I.                               | 23e. Did tot                           | bacco use contr             | ibute to the             | e cause of death?               |
| ord            | v requir<br>been si<br>should l  | ted           | Hizneime   | rs disea.  | se , to                                  | ulure  | 70  | 1 □ Y€                                 | es 2 🗆 No                   | 3 🗌 Proba                | ibly 4 Minknown                 |
| Vital Records, | e iaw r<br>has be  | Completed by  | thrive   |  |  |  |   | 24a. Was a autops                      |                             | Vere autop               | sy findings available           |
| _<br>          | Th<br>ate<br>pag   | Соп           | ,  |  |  |  |   | perforç                                | ned2                        | leath?                   | pletion of cause of             |
| /ita           | ician:<br>certific<br>rector,  | Be            | 25. Was case referred to medical examiner?   |  |  |  | 26. Place of Death                          |  |                             |                          |                                 |
| of             | Physician:<br>this certific<br>ral director,   | ဥ             | 1 ☐ Yes 2 No   | Hospital: 1   Inpatie                                  |  |  | 4   Nursing Ho                              | me 5 Reside                            | ence 6 Othe                 | or (Specify)             |                                 |
|                |  | lon           | 27. Manner of Death  Natural 5 Pendin  |  | ry 28b. Time o<br>lnjury                 | Work   |   | 28d. Describe ho                       | w injury occurr             | эd                       |                                 |
| isi            | eat<br>or:   | cat           | 2 ☐ Accident investig<br>3 ☐ Suicide 6 ☐ Could r   | ot be  | A.1                                      |  | Yes 2 □No                                   |  |                             |                          |                                 |
| Division       | i Pite   | Certification | 4 Homicide determ  | ned 288. Place of Injur                                | ury - At home, farm, str<br>c. (Specify) | eet, factory, office                                   |   | 28f. Location (St.<br>City or Town     | reet and Numbe<br>n, State) | er or Rurai              | Route Number,                   |
|                | To the Hospital within 24 hours a To the Funeral I completely filled   |               | 29a. Certifier Certifyin   | g Physician: To the best                               | of my knowledge deat                     | occurred at the tim                                    | data and place                              | and due to the en                      |                             |                          |                                 |
|                | P Fu   | edicai        | (Check only   Medical (  | xaminer: On the basis of<br>and manner sta             | examination and/or in                    | estigation, in my op                                   | pinion, death occurr                        | ed at the time, da                     | ate and place, a            | and due to               | the cause(s)                    |
|                | To the within 2. To the Complete   | M             | 29b. Signature and title of certifier  |  |  | 29c. License   | number                                      | - 29                                   | 9d. Date signed             | (Month, D                | ay, Year)                       |
|                |  |               | > MILLION  | MI MI  |  | 15   | 8572  | - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | a acus he                   | , 12                     | 2005                            |
|                | 10   |               | 30. Name and address of person   | who completed cause of de                              | eath (Item 23a) (Type.                   | Print)   | 01 2  | L 212                                  | ecemul<br>1                 | L 10,                    | ,2005<br>redenick               |
| 4 1            | Ψ Sta  | te            | 31. Date filed (Month, Day, Year)  | 2005   | s Signature                              | spinal   | nd suit                                     | L 310                                  | Yrin                        | cet                      | realnex                         |
| 3              | Registr  | ar            | DEC  | T3 5002  | Region St                                | GOBALL   |   |  |                             |                          |                                 |

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registrar

2005

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State of Maryland / Department of Health and Mental Hygiene

|                            |  |                  | For<br>State<br>Registrar   | State of Ma                                     | -                     |             | artment of F<br>rtificate of             |              |                 |                   | giens<br>Reg. Ne | 1115                     | 42447   |
|----------------------------|--|------------------|---|---|-----------------------|-------------|--|--------------|-----------------|-------------------|------------------|--------------------------|---|
|                            |  |                  | Decedent's Name (First, Middle, La.   | st)   |                       |             |  |              |                 | 2. Date of De     |                  | V                        | 3. Time of Death                                    |
|                            | Physici  |                  | MILDRED   | L. Whii   | E                     |             |  |              |                 | Month<br>Decem    | Da<br>loo N      | 7 2 co                   | 5 12.20 AM  |
|                            | /Medic   | 41               | 4a. Facility Name (If not institution, giv  |   |                       |             | 4b. City, Town, o                        | r Locatio    |                 | 0 000             |                  | . County of Dea          |   |
|                            | Examin   | er               | CATONSVILLE COMM  |   |                       |             | CATONS                                   |              |                 |                   |                  | BALTIM                   | ORE   |
|                            |  |                  | 5. Social Security Number 6. S  | 17  | e (In yrs. last birti | hdayl       | If Under 1 Year                          |              | der 24 Hrs.     | 8. Date of Bir    | th               |                          |   |
|                            | Funeral  |                  | 218–20–7855   | _M 210F   |                       | rs.         | Months Days                              | Hour         | s Min.          | (Month, Da 7/13/1 | y, Year          | V.                       | rthplace (State or Foreign<br>Jountry)<br>irqinia   |
|                            | Director   | }                | Usual Residence of Decedent   |   | 13                    | _           |  |              |                 | 1/13/1            | 220              | V.                       | rrgriita  |
|                            | and **   |                  | 10a. State 10b. County  |   | 10c. City, Town       | or Lo       | cation                                   |              |                 |                   |                  |                          | 10d. Inside City Limits                             |
|                            | Many l   | ō                | Maryland Baltim   | ore   | Cato                  | ารข         | ville                                    |              |                 |                   |                  |                          | 1 <b>x</b> Yes 2 □ No                               |
|                            | he N   | ect              | 10e. Street and Number  | .020  | 5455                  |             | 10f. Zip Code                            |              |                 |                   | 10a Ci           | itizen of What C         | ountry?   |
|                            | be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Madical Examinar must be mailing at            | Funeral Director | 16 Fusting Ave.   |   |                       |             | 2122                                     | 8            |                 |                   |                  | USA                      |   |
|                            | ath a  | rai              |   | 40 Was Danadani I                               | Consider III C        | 42.1        |  |              | Origin? (Spe    | cify Voc or No    |                  | 14. Race - Am            | erican Indian                                       |
|                            | er de<br>tem   | nne              | 11. Marital Status  | 12. Was Decedent I<br>Armed Forces?             |                       | 13.         | Was Decedent of H<br>If Yes, specify Cub | an, Mexi     | can, Puerto F   | Rican, etc.)      |                  | Black, Wh                |   |
| 36                         | o. or  | by F             | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ☐ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ | 10                    |             | 1 ☐ Yes 2 🛣 No                           | Spec         | ify:            |                   |                  | Specify: W               | hite  |
| 9500-91212                 | ural   | d b              |   |   | 160                   | Dogg        | dent's Usual Occup                       | nation       |                 |                   | 16b k            | Kind of Business         |   |
| Ş                          | nat  | Be Completed     | 15. Decedent's Ed<br>(Specify only highest gra  | ade completed)                                  | 10a.                  | (Give       | kind of work done DO NOT use retire      | during m     | nost of working | ng                | 100, 1           | (IIId OI Dusiiies        | a modatry   |
| 2                          | within 72<br>ene.<br>than "nai   | d'H              | Elementary/Secondary (0-12)   | College (1-4or 5                                | +)                    |             | ating                                    | ۵)           |                 |                   | Mod              | ore Rus                  | iness Forms   |
|                            | filed v<br>Hygie<br>other t<br>ent, th   | ပိ               | 17. Father's Name (First, Middle, Last,   | 1   |                       |             |  | 18 Ma        | ther's Name     | (First, Middle    |                  |                          |   |
| Ē                          | tal h  | Be               | George Harris   | ,   |                       |             |  |              |                 | ice La            |                  |                          |   |
| <u>×</u>                   |  | ို               |   |   |                       |             |  |              |                 |                   |                  |                          |   |
| Maryland                   | S a a s  |                  | 19a. Informant's Name/Relationship (  |   |                       |             | ng Address (Street                       |              |                 |                   |                  |                          |   |
|                            | 1 and 3<br>Health<br>tem 27<br>other tr  |                  | JoAnne Mitchell/  | daugnter  |                       |             | N. Divi                                  | STON         |                 |                   |                  |                          |   |
| 9                          | es 1 a<br>of Hea<br>of Item<br>f Item<br>r othe  |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3  | Removal from State                              | cemeter               | , crer      | sition (Name of<br>matory or other pla   |              |                 | ate               |                  | ocation - City o         |   |
| Ĕ                          | Pages<br>nent of<br>ant: if it<br>ury or o   |                  | '4 □Donation 5 □ Other (Specif  |   | Salisb                | ury         | Cremato                                  | ry           | 12/8/           | 05                | Sa               | alisbury                 | , MD  |
| altimore,                  | permit. Pages<br>Department of<br>Importent: If It<br>any injury or o  |                  | 21. Signature of Funeral Service Licer  | nsee  |                       | 22          | Wannand Addy                             | ss of Fa     | eral H          | Iome Pr           | ofes             | ssional                  | Association   |
| n                          | P P E S  |                  | the Court of  | Bannon  | S CFSP                |             | 501 Snow                                 | Hil          | 1 Rd.,          | Salis             | bury             | y, MD 2                  | Association<br>1804                                 |
|                            |  |                  | 23a. Part1. Enter the disease, or com   | plications that caused                          | the death. Do n       | ot ent      | er the mode of dyir                      | ng, such     | as cardiac or   | r respiratory a   | rrest,           |                          | Approximate<br>Interval Between                     |
|                            | Dharatataa   |                  | shock, or heart failure. List only<br>Immediate Cause (Final  | One cause on each in                            | 0 . 1                 | - 0         | Tal                                      |              | 10              |                   |                  |                          | Onset and Death                                     |
|                            | Physician /Medical   |                  | disease or condition resulting in death)  | a. Due to for as                                | a consequence of      | مان         | FUF (                                    | 771          | 6011            | 1 ~ 1             |                  |                          | 1 day   |
| - Pr                       | Examiner   |                  |   | Due to (or as                                   | a consequence o       | ).<br>  ^ ( | - Hip                                    |              | Torch           |                   | ,                |                          | 1 day   |
|                            |  | 10               | Sequentially list conditions,   | b. Due to (or as                                | a consequence of      | f):         | - ////                                   |              | 1400            | -00               | 7 7              | 7                        | ' /   |
|                            | ped<br>Islt  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ,   |                       |             |  |              | 208             | The               | 1                | ( )                      |   |
| _                          | and<br>and<br>I-trar   | xar              | that initiated events<br>resulting in death) Last   | cDue to (or as                                  | a consequence o       | of):        |  |              | 1               | Ja .              | 01               | 7.                       |   |
| 9                          | be e   | a.               |   |   |                       |             |  |              |                 | May 18            | 20               | 1                        |   |
| 58760,                     | icate be executed<br>physician and<br>s the burial-transit   | edicai           | •   | _ d   |                       |             |  |              |                 | (,,,,,            |                  |                          |   |
|                            |  |                  | IF FEMALE:  | 23c. If yes, outcome                            | of pregnancy          |             |  |              | 10              | 4,                |                  | 22d Date of de           | diven   |
| Вох                        | eath certific<br>attending p   | ian              | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth                                    | 2 Fetal death         |             | Ectopic pregnanc                         | y (          |                 | •                 |                  | 23d. Date of de<br>Month | Day Year  |
|                            | the a  | Physician/M      | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4□ Pregnant at<br>9□ Unknown                    | ume or death          | 2           | Other (specify) _                        |              |                 |                   |                  |                          |   |
| 0.                         | The law requires that the death certif<br>the has been signed by the attending<br>page 2 should be detached for use a  | Ph               | Part II. Other significant conditions   | contributing to death b                         | ut not resulting in   | the II      | nderlying cause an                       | en in Pa     | urt I           | 23e. Did t        | obacco           | use contribute           | to the cause of death?                              |
| Ś                          | res ti   | by               |   | tie cist  |                       |             |  |              |                 |                   | Yes 2            |                          | Probably 4 Unknown                                  |
| 210                        | w require<br>been si<br>should b   | Completed        | Dejum   | 3.4 63,7  | 1/2/1                 | 7           |  |              |                 | -                 |                  |                          |   |
| e<br>C                     | e law has by   | pie              |   |   |                       |             |  |              |                 | 24a. Was<br>autor | osy              | prior to                 | utopsy findings available<br>completion of cause of |
| m m                        | The<br>ate h<br>page   | NO.              |   |   |                       |             |  |              |                 | 1 Yes             | rmed?<br>2□N     | death? 1 ☐ Ye            | s 2 No  |
| ta                         | ian:<br>rtifici  | Be (             | 25. Was case referred to medical  |   |                       |             |  | 26. Pl       | ace of Death    | (Check only o     | опе)             |                          |   |
| >                          | ysic<br>is ce<br>direc   | To               | examiner?<br>1 ☑ Yes 2 ☐ No   | Hospital: 1 Inpatie                             | nt 2 ER/Out           | patier      | nt 3 DOA Ott                             | ner: 4 🕦     | Nursing Hon     | ne 5 Resi         | dence            | 6 □Other (Sp.            | ecify)  |
| Division of Vital Records, | g Ph<br>ter th<br>neral  |                  | 27. Manner of Death   | 28a. Date of Inju<br>(Month, Da                 | ry 28b. T             | ime o       | f 28c. Inju                              | ry at<br>rk? | 2               | 8d. Describe      | how inju         | ury occurred             | 1.21  |
| <u>o</u>                   | ndin<br>ath.<br>r: Afr<br>e fur  | ertification;    | 1 □ Natural 5 □ Pending 2 ☑ Accident investigation  |   | 2005-8                |             | <b>A</b> ,M 1□                           | Yes 2        | No No           | Pt.               | fell             | from                     |   |
| <u>S</u>                   | Atte   | ific             | 3 ☐ Suicide 6 ☐ Could not be determined   |   | ury - At home, far    | m, str      | reet, factory, office                    |              | 2               | 8f. Location (    | Street a         | nd Number or F           | Rural Route Number,                                 |
| ā                          | s afte   | Cert             | - Institution   |   | g home                |             |  |              |                 | Catons            |                  |                          |   |
|                            | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page |                  | 29a. Certifier 1 Certifying Pl  | nysician: To the best                           | of my knowledge       | , deat      | h occurred at the ti                     | me, date     | and place, a    | ind due to the    | cause(s          | s) and manner a          | s stated.   |
|                            | ne Hc  | Medicai          | (Check only 2 Medical Examone)  | miner: On the basis of<br>and manner sta        | ated.                 |             |  |              |                 |                   |                  |                          |   |
|                            | To th<br>To th<br>Somp   | Me               | 29b. Signature and title of certifier   | ///   | know                  | P           | 29c. Licens                              | se numb      | er              |                   | 29d. Da          | ate signed (Mor          | th, Day, Year)                                      |
|                            | 0  |                  | Mulling   | wo  | MO                    | Į           | D3                                       | 691          | +2              |                   | Dec              | ember                    | 8,2005  |
|                            | N.   |                  | 30. Name and address of person who  | completed cause of d                            | eath (Item 23a) (     | Туре.       | Print)                                   |              |                 |                   |                  | 1.1.4. A                 | 1th, Day, Year) 8, 2005 45, 21, 228                 |
|                            | 5  |                  |   | AKHIA, M  | 1. 100                | 9           | Freder                                   | ick          | Rd.             | Cafer             | 40               | the , "                  | 7 6168  |
|                            | Sta  | te               | 31. Date filed (Month, Day, Year)   |   | ar's Signature        |             | 4  |              |                 |                   |                  |                          |   |
|                            | Registi  |                  | DEC 1 6   | 2005  | co. K                 | 1           | Cooks                                    |              |                 |                   |                  |                          |   |
|                            |  |                  |   | Frank C. S.                                     | 1000                  | To the last | Dr                                       |              |                 |                   |                  |                          |   |

|                     |  |                   | 1- For State of Maryland / Registrar  |                       |   | f Health and<br>of Death      | d Mental Hy  | giene                   | 11115                                  | 42448  |
|---------------------|--|-------------------|---|-----------------------|---|-------------------------------|--|-------------------------|--|--|
|                     | Physic<br>/Medi  |                   | 1. Decedent's Name (First, Middle, Last) Audrey Lucinda Williams  |                       |   |                               | 2. Date of De<br>Decemb  |                         | 0, 200                                 | 3. Time of Death 11:35 AMM                         |
|                     | Exami  |                   | 4a. Facility Name (If not institution, give street and number) Citizens Care & Rehabilitation Ce  | enter                 | 4b. City, Tow<br>Fred                         | n, or Location of D<br>erick  | eath   | 4c.                     | County of De<br>Freder                 | ick  |
| 1                   | Funeral<br>Director  |                   | 5. Social Security Number 6. Sex 7. Age (In yrs. last b)  |                       | If Under 1 Ye<br>Months Da                    |                               | 8. Date of Bi  | y, Year)                | 9. E<br>927 Ma                         | Birthplace (State or Foreign<br>County)<br>aryland |
|                     | Maryland<br>f show   | or                | Usual Residence of Decedent  10a. State  10b. County  Maryland  Frederick  10c. City, Tow   | wn or Local           |   |                               |  |                         |  | 10d. Inside City Limits Yes 2 □ No                 |
|                     | h with the   | Funeral Director  | 10e. Street and Number<br>1900 Rosemont Ave.  |                       | 10f. Zip Cod<br>21                            |                               |  |                         | izen of What                           |  |
| 036                 | 72 hours after death with the Maryland<br>natural; or Itama 23a or 28a-f show<br>dital Examinar must be notified at  | þ                 | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:  |                       | as Decedent of es, specify C                  |                               | (Specify Yes or No<br>uerto Rican, etc.)   | )-                      | 14. Race - Ar<br>Black, Wi<br>Specify: |  |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar intest be notified at DDGs. | Completed         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  | (Give kin<br>life. DO | nt's Usual Oc<br>nd of work do<br>NOT use rel | ne during most of t<br>rired) | working  |                         | nd of Busines                          | •  |
| yland               | 2 should be file and Mental Hy is marked oth raumatic event  | To Be (           | 17. Father's Name (First, Middle, Last)  John Grayson Wiles   |                       |   |                               | Name (First, Middle<br>1 Rebecca   |                         |  |  |
| , Mar               | and 2 sho<br>salth and<br>n 27 is ma<br>er traums  |                   | 19a. Informant's Name/Relationship (Type, Print)  Mark Steven Whitmore, son   | b. Mailing A<br>85 Ma | Address (Stre                                 | et and Number or<br>od Ct., H | Rural Route Numb   | er, City o<br>⊇rry      | W Va.                                  | . Zip Code)<br>25425                               |
| Baltimore,          | Pages 1<br>ment of He<br>ant: If Itan<br>ury or oth  |                   | 20a. Nethod of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  | ery, cremati          | tory or other p                               | ry Dec. 23,                   | Date 2005  |                         | cation - City o                        | or Town, State                                     |
| <b>Balt</b>         | permit. Pag<br>Department<br>Important: I<br>any injury o  |                   | 21. Signature of Euneral Service Licensee  MO0255   | TOO                   | Last  | Unuren S                      | ord PA Fun<br>St., Fred  | erici                   | L Home                                 | 21701  |
| 7                   | Physician physician and physician and physician and physician and the private transit  | Examiner          | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one fause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. John Line List only one fause on each line.  a. John Line List only one fause on each line.  a. John Line List only one fause on each line.  Due to (or as a consequence cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence cause (Disease or injury that initiated events resulting in death) Last | of):                  | _   |                               | liac or respiratory a  |                         |  | Approximate Interval Between Onset and Death       |
| P.O. Box 68760      | The law requires that the death certificate be<br>tie has been signed by the attending physici<br>bage 2 should be detached for use as the bu  | Physician/Medical | d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  d.  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown   | 5 □ Ot                | stopic pregnar<br>ther (specify)              |                               |  | 2                       | 3d. Date of de<br>Month                | elivery<br>Day Year                                |
|                     | w requires the   | þ                 | Part II. Other significant conditions contributing to death but not resulting in  | in the unde           | erlying cause                                 | given in Part I.              | 23e. Did to  | 1                       | -                                      | to the cause of death?  Probably 4 □Unknown        |
| Vital Records,      |  | e Completed       | 25. Was case referred to medical  |                       | - Andrews                                     |                               | 1 Tes  | rmed?<br>2 X No         | 24b. Were a prior to death?            |  |
| DIVISION Of VI      | iing Phys  | atlon: To B       | examiner?  1  | Time of<br>Injury     | 28c. In                                       | Other: 4 Nursing              | Heath Check only on Home 5 Residence 1 Res | lence 6                 |  | ecify)   |
| Š                   | i gite   | Certification:    | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)   | arm, street,          | factory, offic                                | ө                             | 28f. Location (S<br>City or Tox  | street and<br>m, State) | Number or F                            | lural Route Number,                                |
|                     | To the Hospital or within 24 hours after To the Funeral Discompletely filled in  | Aedical           | 29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge  Medical Examiner: On the basis of examination and manner stated.   | e, death occurrencest | tigation, in my                               | opinion, death oc             | ce, and due to the c<br>curred at the time, o  | cause(s) a<br>date and  | and manner a<br>place, and du          | s stated.<br>e to the cause(s)                     |
|                     | 0 3 € 5 E  | 2                 | 29b. Signature and title of confiring.  | /                     | 2   | nse number<br>-/ 397          | 7/   | Dece                    |  | th, Day, Year)<br>20, 2005                         |
|                     | 5  |                   | 30 Name and address of person who completed gause of death (Item 23a) ( RODERT L. Kaufmann  | 2                     | F   | reder                         | ick, 11  | nd.                     |  |  |
| *                   | Sta<br>Registra  |                   | 31. Date filed (Month, Day, Year) DEC 3 0 2005  | 400                   | whi   |                               |  |                         |  |  |

|          |  | •                | For State Registrar  | State of Marylan   |                        | irtment of H<br><i>tificate of L</i>     |   |                                 | jiene           | 05                  | 42449                             |
|----------|--|------------------|--|--|------------------------|--|---|---------------------------------|-----------------|---------------------|-----------------------------------|
|          |  |                  | Decedent's Name (First, Middle, Las  | t)   |                        |  |   | 2. Date of Dea<br>Month         | th              | Vaar                | 3. Time of Death                  |
|          | Physicia<br>/Medic   |                  | Luther Fra   | nk Will:   | Lams                   |  |   | Decembe                         | r 5             | 2005                | 8:38 a M                          |
|          | Examin   |                  | 4a. Fecility Name (If not institution, give  | street and number)   |                        | 4b. City, Town, or                       | Location of Death                         |                                 | 4c. Count       | ty of Oeath         | 1                                 |
|          |  |                  | Holy Cross Hospi   | tal  |                        | Silver                                   |   |                                 |                 | tgome               |                                   |
|          | Funeral  |                  | 5. Sociaf Security Number 6. Se  | XM 2 F   |                        | If Under 1 Year<br>Months Days           | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Birth<br>(Month, Day | , Year)         | 9. Birth            | place (State or Foreign<br>untry) |
|          | Director   |                  | 577-66-8014  | 55   | Yrs.                   |  |   | Jan. 23                         | <b>,</b> 1950   | Nort                | h Carolina                        |
|          | and *  |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. Cit   | y, Town or Lo          | cation                                   |   |                                 |                 |                     | 10d. Inside City Limits           |
|          | Manyl<br>f ehc   | ō                | MD Montgome  | ry County S  | ilver S                | Snrino                                   |   |                                 |                 |                     | 1 X Yes 2 ☐ No                    |
|          | 288-   | rec              | 10e. Street and Number   | ity douncy b.  | LIVOI                  | 10f. Zip Code                            |   | 1                               | 10g. Citizen of | What Co             | untry?                            |
|          | 3a or  | <u> </u>         | 40 Long Green Ct.  |  |                        | 20906                                    |   |                                 | US              | A                   |                                   |
|          | ms 2   | Funeral Director | 11. Marital Status   | 12. Was Decedent Ever in U   | .S. 13. V              |  | ispanic Origin? (Sp<br>n, Mexican, Puerto | ecify Yes or No-                |                 | ace - Amer          | ican Indian,                      |
| D        | or ite   | Ē                | 1 Never Married 2 Married  | Armed Forces?<br>1 ☐ Yes 2 ( <b>X</b> No<br>If Yes, Give                               |                        | Tes, specify Cuba                        | Specify:                                  | ricall, etc./                   | Spec            | ack, White          | , etc.                            |
| 20-0     | rai', c  | d by             | 3 Widowed 4 Divorced   | Year or Dates:   |                        |  |   |                                 |                 |                     | Black                             |
| ก็       | 72 h   | etec             | 15. Decedent's Ed<br>(Specify only highest grad  | ucation<br>de <i>completed)</i>  | 16a. Deced<br>(Give    | dent's Usual Occup<br>kind of work done  | ation<br>during most of work<br>I)        | ring                            | 16b. Kind of I  | Business/I          | ndustry                           |
| 7        | han han  | Completed        | Elementary/Secondary (0-12)  | College (1-4or 5+)   | Engir                  |  | ,   |                                 | Mont C          | o Duh               | lic Schools                       |
| 7        | Hygie<br>ther t<br>nt, th  |                  | 17. Father's Name (First, Middle, Last)  |  | Engri                  | IEEI                                     | 18. Mother's Nam                          |                                 |                 |                     | TIC SCHOOLS                       |
| yland    | ntai l   | Be C             | Earlie Frank Wil   | liamo  |                        |  | Nancy Mo                                  |                                 |                 | ,                   |                                   |
| Ē        | mark<br>mark   | ဥ                | 19a. Informant's Name/Relationship (7  |  | 19b. Mailin            | g Address (Street                        | and Number or Rur                         |                                 | r, City or Town | n, State, Z         | ip Code)                          |
| Z        | od 2 street  |                  | Shirley Williams/  |  | 40 Lo                  | ong Green                                | Ct. Sil                                   | lver Spr                        | ing. M          | D. 20               | 906                               |
| ē,       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23e or 28e-f show eny injury or other traumatic event, If a Medical Examinat must be notified at Once. |                  | 20a. Method of Disposition   | 20b. F   |                        | sition (Name of<br>natory or other place |   |                                 | 20c. Location   |                     |                                   |
| baltimor | age:<br>ent of<br>ry or  |                  | 1 ☑ Surial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify  | Hemoval from State   | _                      | Cemetery                                 | 1   | -2005                           | Washin          | gton                | . D.C.                            |
|          | oorta  |                  | 21. Signature of Funeral Service Licen   |  |                        |  | s of Facility<br>S Funeral                |                                 |                 |                     |                                   |
| ă        | Ped F & g  |                  | A PAIL   | ashell   |                        |  | St. N.W.                                  |                                 |                 | DC 20               | 011                               |
| Н        |  |                  | 23a. Parti Enter the disease, or comp<br>shock, or heart failure. List only                              | olications that caused the deat  |                        |  |   |                                 |                 |                     | Approximate<br>Interval Between   |
|          | Physician  |                  | Immediate Cause (Final disease or condition  | Septic Show  | ·k                     |  |   |                                 |                 |                     | Onset and Death                   |
|          | /Medical   |                  | resulting in death)  | Due to (or as a conseq   |                        |  |   | 1                               |                 |                     |                                   |
|          | Examiner   |                  | Sequentially list conditions,  | Refractory   |                        | emic                                     |   |                                 |                 |                     |                                   |
| -        | D 4  | ner              | If day leading to approachas   | Due to (or se a coneaq   |                        |  |   |                                 |                 |                     |                                   |
|          | ecute<br>and<br>trans  | Examin           | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last | c. Refractory Due to (or as a conseq   |                        | olic Acid                                | os1s                                      |                                 |                 |                     |                                   |
| 8/60,    | cien a   | E                |  | Acute Renal  |                        | ıre                                      |   |                                 |                 |                     |                                   |
| ğ        | ficate be executed<br>physicien and<br>is the burial-transit   | dlcal            |  | d  |                        |  |   |                                 |                 |                     |                                   |
|          | leath certifi<br>ettending p<br>for use as   | a)               | IF FEMALE:   | 23c. If yes, outcome of pregna   | ancy                   |  |   |                                 | 23d. D          | ate of deli         | verv                              |
| ă        | death certif<br>e ettending<br>d for use as  | Physician/M      | 23b. Was decedent pregnant in the past 12 months?  | 1 Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of c                                     | ıl death 3 [           | Ectopic pregnancy Other (specify)        |   |                                 |                 | fonth               | Day Year                          |
| )        | the d<br>y the<br>iched  | ysi              | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□ Unknown   |                        |  |   |                                 |                 | (2.1) =             |                                   |
| λ,<br>J  | w requires thet the de<br>been signed by the t<br>should be detached   | by Pt            | Part II. Other significant conditions of   | ontributing to death but not res   | ulting in the u        | ndertying cause giv                      | en in Part I.                             | 23e. Did to                     | bacco use co    | ntribute to         | the cause of death?               |
|          | requires<br>een sign<br>hould be   |                  |  |  |                        |  |   | 1□Y                             | es 2 🗆 No       | 3 🗆 Pro             | obably 4X\(\text{Unknown}\)       |
| Cord     | iaw red<br>as bee<br>2 shor  | Completed        |  |  |                        |  |   | 24a. Was a                      |                 | . Were au           | topsy findings available          |
| ř        |  | E                |  |  |                        |  |   | autop:<br>perfor<br>1 Yes       | med?            | death?              | completion of cause of            |
|          | Physicien: The<br>r this certificate h<br>ral director, pega   | 0                | 25. Was case referred to medical   |  |                        |  | 26. Place of Dear                         |                                 |                 |                     |                                   |
| <u> </u> | Physicien:<br>r this certific<br>ral director,   | To B             | examiner?<br>1 ☐ Yes 2 ②KNo  | Hospital: 1 XInpatient 2 □   | ER/Outpatier           | nt 3 DOA Oth                             | er: 4 🗌 Nursing Ho                        | ome 5 Resid                     | ence 6 🗆 O      | ther (Spec          | cify)                             |
|          | ng Ph<br>ter th<br>nerai   |                  | 27. Manner of Death 1 ANatural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury | f 28c. Injur<br>Wor                      | y at<br>k?                                | 28d. Describe h                 | ow injury occu  | benı                |                                   |
| <u>o</u> | Attending ir death. ector: After by the fune   | atle             | 2 Accident investigation   |  |                        | M 1 🗆                                    | Yes 2 □No                                 |                                 |                 |                     |                                   |
| _        | 2 2 2 2  | Certification;   | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of Injury - At h<br>building, etc. (Special                                 | ome, farm, str<br>fy)  | reet, factory, office                    |   | 28f. Location (S<br>City or Tow |                 | 1 <i>ber or R</i> u | ral Route Number,                 |
| _        | oitai c<br>urs at<br>arai D  |                  |  |  |                        |  |   | 71.45                           |                 |                     |                                   |
|          | To the Hospital of within 24 hours at To the Funeral D completely filled in  | Medical          |  | ysician: To the best of my kno<br>niner: On the basis of examina<br>and manner stated. |                        |  |   |                                 |                 |                     |                                   |
|          | o the  | Me               | 29b. Signature and title of certifier  | and marmer stated.   |                        | 29c. Licens                              | e number                                  |                                 | 29d. Date sign  | ned (Monti          | n, Day, Year)                     |
| ,        | F-3F-8 →   | III              | ) / selt   | Mrs. ml  | 1110                   | DOO                                      | 56153                                     |                                 | 12/5/           | 2005                |                                   |
| 0        | (in)   |                  | 30. Name and address of person who   | completed cause of death (Iter   | n 23a) (Type           |  |   |                                 | ,               |                     |                                   |
|          | ()   |                  | Kristine Nowak   |  |                        |  | lver Spri                                 | ng, MD.                         |                 |                     |                                   |
| Ç.       | Sta  |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signa  | ature.                 |  |   |                                 | ,,,             |                     |                                   |
|          | Registi  |                  | DEC 13 2005  | Glade &  | A STATE OF             | 2)                                       |   |                                 |                 |                     |                                   |

|                     |  |                 |   | partment of Health and Mental H   | 2005 1.21.50                                 |
|---------------------|--|-----------------|---|---|--|
|                     |  | 1               | Decedent's Name (First, Middle, Last)   | 2. Date of E  |  |
|                     | Physic<br>/Medi  |                 | Elizabeth A. Wasshausen   | Month<br>Decemb   | Day Year                                     |
|                     | Examir   |                 | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death  | 4c. County of Death                          |
|                     |  | 9               | National Lutheran Home  | Rockville   | Montgomery                                   |
| г                   | Funeral  |                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday  | Months Days Hours Min (Month I  | irth 9. Birthplace (State or Foreign         |
|                     | Director   |                 | 152-30-5757   | July  | 20, 1907 Germany                             |
|                     | ow ow  | Ĺ               | 10a. State 10b. County 10c. City, Town or L   | ocation   | 10d. Inside City Limits                      |
|                     | Many<br>Fish   | ţ               | Maryland Montgomery Rockville   |   | 1 ☐ Yes 2 ☒ No                               |
|                     | r 288  | Director        | 10e. Street and Number  | 10f. Zip Code   | 10g. Citizen of What Country?                |
|                     | hours after death with the Maryland<br>tural; or Itams 23a or 28a-f show<br>at Examiner must be notitized at   | ai D            | 9701 Veirs Drive  | 20850   | U.S.A.                                       |
|                     | ams<br>ams   | Funerai         | 11. Marital Status 12. Was Decedent Ever in U.S. 13.  | Was Decedent of Hispanic Origin? (Specify Yes or N<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.) | o- 14. Race - American Indian,               |
| 36                  | or it  |                 |   | 1 ☐ Yes 2 No Specify:   |  |
| Ö                   | hours<br>tural   | d by            | 3 23 Wildowed 4 Divorced Year or Dates:   |   | Specify: White                               |
| 7                   | in 72<br>"na"<br>Palic   | Completed       | 15. Decedent's Education (Specify only highest grade completed) (Give   | edent's Usual Occupation<br>e kind of work done during most of working<br>DO NDT use retired)             | 16b. Kind of Business/Industry               |
| 77                  | iene.  | шо              | Elementary/Secondary (0-12) College (1-4or 5+)  | Homemaker   | Own Home                                     |
| b                   | Hyg<br>otha  | a               | 17. Father's Name (First, Middle, Last)   | 18. Mother's Name (First, Middle  |  |
| <u>la</u>           | uld be<br>Aenta<br>rked<br>tic ev  | To B            | Max Mueller   | Ida Mueller   | ,  |
| Maryland 21215-0036 | should have some   |                 | 19a. Informant's Name/Relationship (Type, Print) 19b. Mail  | ing Address (Street and Number or Rural Route Numb  | per, City or Town, State, Zip Code)          |
|                     | and 2<br>salth<br>n 27 i   |                 |   | Legends Dr., Southport,   |  |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic evant, the Madical Examiner must be multiped at ance. |                 | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  | osition (Name of Date matory or other place)  | 20c. Location - City or Town, State          |
| Ē                   | Pag<br>ment<br>ant:  |                 | - Delia 2 Goldington 0 Di tamoval nom otate   | itan Crematory 12/9/05  | Alexandria, VA                               |
| Sall                | Depart<br>Import<br>Import<br>Inport<br>Inport   |                 | 21. Signature of Funeral Service Monse  | 2. Name and Address of Facility   |  |
|                     | Q □ □ ■ 0  |                 | W. m. layson  | The Hysong Company, Inc.<br>6510 16th St. NW, Washing   | gton, DC 20012                               |
|                     | /Medical / Medical / Medical / Medical : the purial-transit : the purial-transit :   | dicai Examiner  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, Leny, leading to minimize that cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of): | ascular Accident  | Interval Batween Oviset and Death Uacy       |
| P.O. Box 687        | I the death certiff<br>by the attending<br>ached for use as  | Physician/Medic | 1 Yes 2 No 4 Pregnant at time of death 5 Unknown  | □Ectopic pregnancy<br>□ Other (specify)   | 23d. Date of delivery<br>Month Day Year      |
| ŝ                   | iires tha<br>signed<br>d be det  | by              | Part II. Other significant conditions contributing to death but not resulting in the u  | ndertying cause given in Part I. 23e. Did t   | obacco use contribute to the cause of death? |
| 9                   | w requir<br>been s<br>should   | eted            | coronary on tary  | lifet 10  | Yes 2 No 3 Probably 4 Unknown                |
|                     |  | Completed       | ,   | 24a. Was<br>auto<br>perfic<br>1 U Yes   |  |
| Vita                | Physician: Th<br>this certificate<br>ral director, pag   | Be              | 25. Was case referred to medical examiner?  1 Types 20 New Hospital:  | 26. Place of Death (Check only of   |  |
| ō                   | a = 6  | 2 :             | 1 Inpatient 2 ER/Outpatier  |   |  |
| O                   | ding I<br>th.<br>After<br>funer  | tion            | 27. Manne Death 28a. Date of Injury 28b. Time of Injury 2 ☐ Accident investigation 2 ☐ Accident investigation   | f 28c. Injury at 28d. Describe i Work?  M 1 □ Yes 2 □ No  | how injury occurred                          |
| Division of         | or Attanding<br>after death.<br>Director: After<br>d in by the fune  | Certification:  | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str   |   | Street and Number or Rural Route Number.     |
| á                   |  | Sert            | 4 Homicide determined building, etc. (Specify)  | City or Tov   | vn. State)                                   |
|                     | To the Hospital or At within 24 hours after or To the Funaral Directompletely filled in by   |                 | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death   | n occurred at the time, date and place, and due to the  | cause(s) and manner as stated.               |
|                     | in 24<br>in 24<br>in 24<br>in 24   | edical          | (Check only 2 Medical Examinar: On the basis of examination and/or in and manner stated.  | estigation, in my opinion, death occurred at the time,  | date and place, and due to the cause(s)      |
|                     | To the within 2 To the complete  | Σ               | 29b. Signature and little of certifier  | 29c. License number   | 29d. Date signed (Month, Day, Year)          |
| •                   |  |                 | Charlelly. Karen w  | 11121726 1  | Jecember 8. 2005                             |
|                     | (5)  |                 | 30. Name and address of person who completed cause of death (Item 23a) (Type,   |   | 1,000  |
|                     |  |                 |   | B Dr., Rockville, MD 208  | 350  |
|                     | Stat<br>Registra   |                 | 31. Date filed (Month, Day, Year)  DEC 1 3 2005   | B   |  |

|                     |  | •              | For State   |                           |   |  |                             | artment of I                           |                               | nd Men                     |                                      | gieņe                | 005                                   | 42451   |
|---------------------|--|----------------|---|---------------------------|---|--|-----------------------------|--|-------------------------------|----------------------------|--------------------------------------|----------------------|---------------------------------------|---|
|                     |  |                | State     Registrar Amend     Decedent's Name (First, M.)   | <b>Ltem</b><br>iddle, Las | #10b per  | FH G                                   | 351 17                      | 1:2/06~JH                              |                               |                            | Date of Dea                          | ıth                  |                                       | 3. Time of Death                                      |
| ı                   | Physici<br>/Medio  |                | Lyda  |                           | D.  |  | Willia                      | ms                                     |                               |                            | Month<br>cembe                       | r 8                  | 2003                                  |   |
|                     | Examin   |                | 4a. Facility Name (If not instit  | ution, give               | street and number   | r)                                     |                             | 4b. City, Town,                        | or Location of I              | Death                      |                                      | 4c.                  | County of De                          |   |
|                     |  |                |   |                           | Hospita   |  |                             |  | ver Spr                       |                            |                                      |                      |                                       | gomery  |
|                     | Funeral<br>Director  |                | 5. Social Security Number 326–05–7408   | 6. S                      | 9X 7. A<br>□ M 2 1 F  | Age (In yrs.                           | last birthday)<br>2_ Yrs.   | If Under 1 Year<br>Months Days         |                               | Min. (                     | Date of Birth<br>Month, Day<br>b. 8, | , Year)              |                                       | irthplace (State or Foreign<br>Country)<br>nnsylvania |
|                     | pur *  |                | Usuel Residence of Deceden<br>10a. State 10b. Co.   |                           |   | 10c. Cit                               | y, Town or Lo               | cation                                 |                               |                            |                                      |                      |                                       | 10d. Inside City Limits                               |
|                     | Maryla   | ţ              |   | LIK                       | ntg <b>omery</b><br><del>Ceorge's</del>                                       |  | ,                           |  | Silver                        | Spri                       | ng                                   |                      |                                       | 1 XYes 2 ☐ No   |
|                     | 3s or 28s  | i Director     | 10e. Street and Number 307 E. Un:   | ivers                     | sity Blvd   | •                                      |                             | 10f. Zip Code                          | 209                           | 001                        |                                      | 10g. Citiz           | en of What C                          | Country?<br>I States                                  |
| 920                 | d within 72 hours after death with the Maryland<br>Jiene.<br>r than "natural", or Itama 23a or 28a-1 ahow<br>The Macical Extractional De notified at | by Funerai     | 11. Marital Status  1 Never Married 2   |                           | 12. Was Deceder<br>Armed Forces<br>1  Yes 24<br>If Yes, Give<br>Year or Dates | s?                                     |                             | Was Decedent of If Yes, specify Cut    | oan, Mexican, F               | n? (Specify<br>Puerto Rica | Yes or No-<br>n, etc.)               |                      | 4. Race - Am<br>Black, Wh<br>Specify: | nerican Indian,<br>lite, etc.<br>Black                |
| 2-0                 | 72 ho  | eted           | 15. Dece<br>(Specify only hi  | dent's Ed                 |   |  | (Give                       | dent's Usual Occu                      | during most o                 | f working                  |                                      | 16b. Kir             | nd of Busines                         | s/Industry  |
| 121                 | within iene.   | Completed      | Elementary/Secondary (0-  |                           | College 1-40  | r 5+)                                  | life.                       | DO NOT use retire<br>Audi              | ed)                           | ·                          | ļ                                    |                      | Gover                                 | nment   |
| Maryland 21215-0036 | al Hyg   | Be             | 17. Father's Name (First, Mid<br>Columbu  |                           | ndv   |  | L                           |  | 18. Mother's                  | Name (Fir                  |                                      |                      |                                       |   |
| Ž                   | ss 1 and 2 should be in the solution of Health and Mental I item 27 is marked or other traumatic ever  | ဥ              | 19a. Informant's Name/Relat   |                           |   |  | 19b. Mailir                 | ng Address (Stree                      | t and Number of               | or Rural Ro                |                                      |                      |                                       | Zip Code)   |
|                     | nd 2 salth ar 27 ls  |                | Ruth A. B   |                           |   |  |                             | 8 Syms S                               |                               |                            |                                      |                      |                                       |   |
| Baltimore,          | Pages 1 and 2<br>nent of Health a<br>int: If Item 27 li<br>iry or other tra  |                | 20a. Method of Disposition<br>1 ⊠ Burial 2 ☐ Cremat   |                           |   | 20b. P                                 | lace of Dispo               | sition (Name of<br>matory or other pla |                               | Date                       |                                      |                      |                                       | or Town, State  |
| Itim                |  |                | '4 □Donation 5 □ Other  |                           |   | Li                                     |                             | Memorial<br>.Name and Addr             |                               |                            |                                      |                      | Suitlan                               |   |
| Ba                  | permit. Departr Imports any inju   |                | A.  | 1 Licen                   | Tough   | 11                                     |                             | 4001 Be                                | _                             |                            |                                      |                      | eral Ho                               |   |
|                     |  |                | 23a. Part1. Enter the disease shock, or heart failure.  | e, or comp<br>List only   | olications that caus  | ed the deati                           | h. Do not ent               |  |                               |                            |                                      |                      | , DC                                  | Approximate<br>Interval Between<br>Onset and Death    |
|                     | Pnysician<br>/Medical  | 1              | Immediate Cause (Final disease or condition resulting in death)                                     | -                         |   | ngest:                                 |                             | art Fail                               | ure                           |                            | 317                                  |                      |                                       |   |
| П                   | Examiner   |                | Sequentially list conditions,   |                           | b   |  |                             |  |                               |                            |                                      |                      |                                       |   |
|                     | uted<br>d<br>ansit   | Examine        | if any, leading to immediate cause. Enter Underlying Cause (Discass or injury that initiated events | 4                         | Due to (or a  | as a consequ                           | uence or):                  |  |                               |                            |                                      |                      |                                       |   |
| 90,                 | cate be executed<br>physicien and<br>the burial-transit  |                | resulting in death) Last  |                           | Due to (or a  | as a consequ                           | uence of):                  |  |                               |                            |                                      |                      |                                       |   |
| 38760,              | physic<br>physic<br>the b  | edicai         |   |                           | d   |  |                             |  |                               |                            |                                      |                      |                                       |   |
| .O. Box 6           | that the death certificated by the attending (   | hysician/Me    | IF FEMALE: 23b. Was decedent pregnanin the past 12 months? 1 Yes 2 No 9 Unknown                     |                           | 23c. If yes, outcom<br>1 ☐ Live birth<br>4 ☐ Pregnant<br>9 ☐ Unknown          | 2 Feta<br>at time of de                | Ideath 3                    | Ectopic pregnand<br>Other (specify)    | ey                            |                            |                                      | 2                    | 3d. Date of d                         | elivery<br>Day Year                                   |
| α.                  | og og  | by P           | Part II. Other significant con  | ditions o                 | ontributing to death  | but not resi                           | ulting in the u             | nderlying cause g                      | ven in Part I.                |                            |                                      | bacco us             |                                       | to the cause of death?                                |
| Vital Records,      | law requires<br>as been sign<br>2 should be  | ompleted       |   |                           |   |  |                             |  |                               | _                          | 24a. Was a                           |                      |                                       | autopsy findings available                            |
| l Re                | 0 5 0  | Comp           |   |                           |   |  |                             |  |                               | _                          | autops<br>perfori<br>1 🗌 Yes         | sy<br>med?<br>2 □XNo | death?                                | completion of cause of                                |
| /ita                | or illic   | Be (           | 25. Was case referred to me examiner?   | -                         | (1  |  |                             |  | 26. Place of                  |                            | eck only or                          | 10)                  |                                       |   |
| of \                | Physicia<br>this cert<br>al direct   | 6              | 1 Yes 2 No  |                           | Hospital:<br>1 ☐ Inpa<br>28a. Date of In                                      |  | ER/Outpatier<br>28b. Time o | t 3 DOA                                | her: 4 Nursi                  |                            | 5 🗌 Reside                           |                      |                                       | ecify)  |
| OU                  | ding<br>After<br>fune  | tion           | 1 Natural 5 Pe  | nding<br>estigation       | (Month, E   | Day Year)                              | Injury                      | Wo                                     | irk?<br>]Yes 2 ☐ No           |                            | Describe in                          | ow injury            | occurred                              |   |
| Division            | or Attendiater death<br>Director: A  | Certification: | 3 Suicide 6 □ Co  | uld not be<br>termined    | 28e. Place of I   | njury - At ho<br>etc. <i>(Specif</i> ) | ome, farm, str              | eet, lactory, office                   |                               |                            | ocation (Si                          |                      | Number or F                           | Rural Route Number,                                   |
| _                   | To the Hospital or At within 24 hours after of To the Funeral Directompletely filled in by   | edical Ce      | (Check only 2 Med   | ifying Ph                 | ysician: To the besinner: On the basis  | of examina                             | wledge, deat                | n occurred at the t                    | ime, date and popinion, death | place, and o               | fue to the c                         | ause(s) a            | and manner a                          | as stated.<br>ue to the cause(s)                      |
|                     | To the h<br>within 2<br>To the f<br>complet  | Med            | 29b. Signature and title of one   | tifier                    | and manner  | stated.                                | , ^                         |  | se number                     |                            |                                      |                      |                                       | nth, Day, Year)                                       |
|                     | F 5 F 3  |                | · Wilk  | w                         | ian J   | ·N                                     | nale                        | D                                      | 45285                         |                            |                                      | Dec                  | ember                                 | 9, 2005   |
| 1                   | (1)  |                | 30. Name and address of per   | son who                   |   | f death (Item                          |                             |  | ty Blvd                       | l., #1                     | 13, S                                | ilve                 | r Spri                                | ing, MD 2090  |
|                     | Sta<br>Registr   | •              | 31. Date filed (Month, Day, Y   |                           | 3 Regis   | strar's Signa                          | ture                        | · Comment                              |                               |                            |                                      |                      |                                       |   |

|                                     |   |                    | 1 - For<br>State<br>Registrar   | State of Mar   |   | partment of<br><i>ertificate of</i>                        |   | Mental Hy                              | ygiene<br>Reg. No. () (                | 05                       | 42452  |
|-------------------------------------|---|--------------------|---|--|---|--|---|--|--|--------------------------|--|
|                                     | of picture  | s.                 | 1. Decedent's Name (First, Middle, La   |  |   |  |   | 2. Date of D                           |  | Year                     | 3. Time of Death   |
| ×                                   | Physici<br>/Medic   |                    |   | JON, J   | ۲-  |  |   | DEC                                    | 92                                     | 005                      | 335PM  |
|                                     | Examir  | er                 | 4a. Facility Name (If not institution, giv  | e street and number)   |   | 4b. City, Town,  | or Location of Deat                         | h                                      | 4c. County                             | y of Death               |  |
| -                                   | Funeral   |                    | 5. Social Security Number 6. S  |  | In yrs. last birthda                        | y) If Under 1 Yea  | r If Under 24 Hrs                           |  | irth                                   | 9. Birth                 | place (State or Foreign                                  |
| 9                                   | Director  |                    | 245-56-0091   | X <sup>M 2□ F</sup> 6  | 7 Yrs                                       | Months Days  | Hours Min.                                  | Mar. 6                                 | 1938                                   | Nort                     | h Carolina   |
|                                     | and   |                    | Usual Residence of Decedent  10a. State 10b. County                                     | 1  | 0c. City, Town or                           | Location   |   |  |  | 1                        | 10d. Inside City Limits                                  |
|                                     | Manyl   | Į į                | Maryland  |  | Baltimor                                    | :e   |   |  |  |                          | XXYes 2□No   |
|                                     | th the  | lrec               | 10e. Street and Number  |  |   | 10f. Zip Code  |   |  | 10g. Citizen of                        |                          | •  |
|                                     | ath will  | ralD               | 954 Forrest Stre  |  |   | 21202  |   |  | United                                 |                          |  |
| 36                                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: if item 27 ie marked other then "natural", or iteme 23a or 28e-f ehow eny injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Directo | 11. Marital Status  1 Never Married 2 Married  3 Widowed Woroced                        | 12. Was Decedent Eve<br>Agned Forces?<br>14 Yes 2 No<br>If Yes, Give<br>Year or Dates: 0 | 05/56                                       | 3. Was Decedent of<br>If Yes, specify Cu<br>1 ☐ Yes 2 → No | ban, Mexican, Puer                          | Specify Yes or N<br>to Rican, etc.)    |  | ck, White,               |  |
| Maryland 21215-0036                 | 2 hou   | ted t              | 15. Decedent's E  | ducation   | 16a. De                                     | cedent's Usual Occi  | upation                                     | advisor on                             | 16b. Kind of B                         |                          |  |
| 2                                   | ithin 7<br>Ie.<br>Ien "n  | Completed          | (Specify only highest gra<br>Elementary/Secondary (0-12)                                | College (1-4or 5+)   | life  | ve kind of work don<br>a. DO NOT use retir                 | e auring most of wo<br>ed)                  | rking                                  | D                                      | 1                        |  |
| 72                                  | Hygier<br>Her th  |                    | 17. Father's Name (First, Middle, Last,   |  | Sto   | ck Clerk   | 18 Mother's Nat                             | me (First Middle                       | Retail                                 |                          | ustry  |
| and                                 | d be f<br>ental h<br>ked of   | To Be              | Earl Watson, Sr   |  |   |  | Eula Mo                                     |  | o, maioon ooman                        |                          |  |
| ary                                 | shoul<br>ind Me<br>marl<br>umati  | F                  | 19a. Informant's Name/Relationship (  | Type, Print)   | 19b. Ma                                     | uling Address (Stree                                       | et and Number or Ri                         | ural Route Numi                        | ber, City or Town                      | , State, Zip             | p Code)  |
|                                     | and 2<br>salth a<br>n 27 io   | 1 2                | <u>-</u>  | iece   |   |  | Kenly, No                                   |  |  |                          |  |
| Baltimore,                          | Pages 1<br>ment of He<br>ant: if iten<br>ury or oth   |                    | 20a. Method of Disposition  XXBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif   | Removal from State   | cemetery, c                                 | sposition (Name of rematory or other plant Churo           | ch Cem. 12                                  | Date 2/17/05                           | 20c. Location Kenly                    |                          | own, State<br>ch Carolina                                |
| Balt                                | permit. Departitimport. eny inj.  |                    | 21. Signature of Funeral Service Licer  | 1500   |   | Alexander<br>5538 Marl                                     | essof Family<br>Doro Pik                    | Funeral<br>Forest                      | Homes,                                 | P.A.<br>Md. 2            | 0747   |
|                                     |   |                    | 23a. Part1 Enter the disease, or com<br>shock, or heart failure. List only              | plications that caused the   | e death. Do not                             | enter the mode of dy                                       | ring, such as cardia                        | c or respiratory                       | arrest,                                |                          | Approximate<br>Interval Between<br>Onset and Death       |
| K                                   | Physician /Medical  |                    | Immediate Cause (Final disease or condition resulting in death)                         | u  | BRAL  | LNE  | ARCTIO                                      | N                                      |  |                          | 4 days   |
| *                                   | Examiner  |                    |   | Due to (or as a d  | onsequence of):                             |  |   |  |  |                          | 1  |
|                                     | P =   | ner                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying      | b. ————————————————————————————————————  | onsequence of):                             |  |   |  |  |                          |  |
|                                     | and<br>trans  | Examiner           | Cause (Disease or injury that initiated events resulting in death) Last                 | c<br>Due to (or as a c   | ionenguanaa of):                            |  |   |  |  |                          |  |
| 8760,                               | ficate be executed<br>physicien and<br>s the burial-transit   | alE                |   |  | onsoquonos ory.                             |  |   |  |  |                          |  |
| 687                                 | ifficate<br>g phys  | edical             |   | d  |   |  |   |  |  |                          |  |
| Division of Vital Records, P.O. Box | Attending Physician: The law requires thet the death certificath. It death. ector: After this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use as  | Physician/Mo       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome of 1 Live birth 2 (4 Pregnant at tin 9 Unknown                      | Fetal death                                 | 3 □Ectopic pregnan<br>5 □ Other (specify)                  | су  |  |  | ate of delive<br>onth    | ery<br>Day Year  |
| ۳.                                  | s thet i<br>ned by<br>e deta  | by Ph              | Part II. Other significant conditions   | contributing to death but r  | not resulting in the                        | underlying cause g   | iven in Part I.                             | 23e. Did                               | tobacco use con                        | tribute to ti            | he cause of death?                                       |
| ğ                                   | w require<br>been sig<br>should b   |                    |   |  |   |  |   | 1 🗆                                    | Yes 2□No                               | 3 🗌 Prob                 | bably 4 Unknown  |
| Reco                                | The law r<br>ete has be<br>page 2 sh  | Completed          |   |  |   |  |   | 24a. Was<br>auto<br>peri<br>1  Yes     | ormed?                                 | death?                   | opsy findings available<br>impletion of cause of<br>2 No |
| /ita                                | ding Physician: The i<br>h.<br>After this certificate ha<br>funeral director, page  | Be                 | 25. Was case referred to medical examiner?  | 11   |   |  | 26. Place of Dea                            | ath (Check only                        | one)                                   |                          |  |
| of<br>o                             | Physi<br>this o   | J.                 | Yes 2 No<br>27. Manner of Death   | Hospital: 1 Inpatient  |   | IBIT 3 DOA   |   |  | how injury occur                       |                          | 5/)  |
| O                                   | th.<br>: After<br>s fune  | tlon               | ↑ Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Y   | ear) Injur                                  | y W  | ork?<br>□Yes 2□No                           | 200. 2000.                             | now injury cocar                       | 100                      |  |
| Divis                               | i or Attending after death.<br>I Director: After<br>d in by the funer   | Certification;     | 3 Suicide 6 Could not be determined   |  | - At home, farm,<br>Specify)                | street, factory, office                                    | )   |  | (Street and Numb<br>own, State)        | ber or Rura              | al Route Number,   |
|                                     | To the Hospital or Attend within 24 hours after death To the Funerel Director; / completely filled in by the fi   | edical C           | 29a. Certifier (Check only one)  1 Certifying Pt 2 Medical Exam                         | nysician: To the best of r<br>miner: On the basis of ex<br>and manner stated             | πy knowledge, de<br>camination and/or<br>d. | eath occurred at the investigation, in my                  | time, date and place<br>opinion, death occu | e, and due to the<br>urred at the time | e cause(s) and mi<br>, date and place, | anner as s<br>and due to | tated.<br>o the cause(s)                                 |
| )                                   | To th<br>withir<br>To th<br>comp  | Me                 | 29b. Signature and title of certifier   | 054 Mi   | >   |  | t 263                                       | 4                                      | 29d. Date signe                        |                          | Day, Year)   |
| )                                   | (4)   |                    | 30. Name and address of person who  |  | th (Item 23a) (Typ                          | e Print)   |   |  |  |                          | 20215  |
|                                     | Sta<br>Registr  |                    | 31. Date filed (Month, Day, Year)  DEC 1 3 2003   | 2. Registrar's   |   | de   |   |  |  |                          |  |
|                                     |   |                    |   |  |   |  |   |  |  |                          |  |

DHMH 17 Rev 1/2001

Amend item#2, perMD, 12/29/05 IT State of Maryland / Department of Health and Mental Hygiene. 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 100 11 2005 Elbert L. Williams 9:00 aM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rockville

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 4710 Topping Road Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ★M 2 F 74 Yrs Director 578-42-1834 6-27-1931 Virginia Usual Residence of Decedent the Maryland 10a, State Prince Georges City, Town or Location, Takoma Park 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Modical Examinar must be notified at 1 X Yes 2 ☐ No Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 6731 New Hampshire Avenue 20912 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hyglene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ρ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir.
Department of Health and Mental Hyglene.
Important: If item 27 is marked other than any injury or other traumatic event, the M. Elementary/Secondary (0-12) College (1-4or 5+) 12th <u>Warehouse Worker</u> Gerstals Moving Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Williams Pauline Burk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cary Williams -Son 4710 Topping Rd., Rockville, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Maryland National 12-16-2005 | Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 9th St., NW, Washington, DC 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Metastatic Lung Cancer 6 months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 A No 2XNo 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other:  ${}_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6  $\square$ Other (Specify) Sons Home Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2X No ۵ After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred To the Hospital or Attanding 1 Natural 5 Pendina within 24 hours after death. To tha Funerel Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D41715 12-13-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chitra Venkatraman, MD 6201 Greenbelt Rd U3 College Park, MD 20740 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DEC 1 4 2005

| Discontinu  |                  | 1 - State Registrar 1. Decedent's Name (First, Middle, Last)   | ertificate of Death  | 2. Date of Dea                              | Day Van   |
|---|------------------|--|--|---|---|
| Physicia<br>/Medic  |                  | Robert James Ackerman  |  | Decembe                                     | er 28, 2005 11:45 PM  |
| Examin  | er               | 4a. Facility Name (If not institution, give street and number) 97 Patuxent Mobile Estates  | 4b. City, Town, or Location of Deat  Lothian                                       | h   | Anne Arundel  |
| Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 158-50-9825 6. Sex 154 2 F 7. Age (In yrs. last birthda. 7. Yrs.  | If Under 1 Year If Under 24 Hrs Months Days Hours Min.                             | 8. Date of Birt<br>(Month, Da<br>05/18/     | 9. Birthplace (State or Fore<br>Country)                                |
| yland<br>now  |                  | 10a. State 10b. County 10c. City, Town or  | ocation  |   | 10d. Inside City Lim  |
| Ba-fsh  | ctor             | MD Anne Arundel Lothian  |  |   | 1 □ Yes 2-13  |
| with th   | Funeral Director | 10e. Street and Number   | 10f. Zip Code<br>20711   |   | 10g. Citizen of What Country?  USA                                      |
| eath y  | era              | 97 Patuxent Mobile Estates  11. Marital Status 12. Was Decedent Ever in U.S. 13  | . Was Decedent of Hispanic Origin? (S  |   |   |
| 72 hours after death with the Maryland<br>naturel', or items 23a or 28a-f show<br>disal Exarterer must be nydified at   | by               | Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:  | If Yes, specify Cuban, Mexican, Puerl  | o Rican, etc.)                              | Black, White, etc.  Specify: White                                      |
| 72 ho   | ted              | 15. Decedent's Education 16a. Dec<br>(Specify only highest grade completed) (Giv   | edent's Usual Occupation   | rkina                                       | 16b. Kind of Business/Industry  |
| within<br>ene.<br>than "  | Completed        | Elementary/Secondary (0-12)   College (1-4or 5+)   | e kind of work done during most of wor<br>DO NOT use retired)<br>arian Technician  | King  | Federal Government  |
| filed w<br>Hygiel<br>Ather th   | ပိ               | 2 LIDT:  |  | ne (First Middle                            | Maiden Sumame)  |
| should be filed within 72 hours<br>nd Mental Hygiene.<br>marked other than "natureli",<br>imatic event, the Mudical Exa                                       | To Be            | James Walter Ackerman  |  | ara Krie                                    |   |
| ilth ar<br>27 is<br>r trau  |                  |  | ling Address (Street and Number or Ru<br>Patuxent Mobile Es                        |   |   |
| 8 = 5   |                  | 1 Li Buriai 2 Libernation 3 Li Hemovai from State  | position (Name of ematory or other place)  ke Crematory                            | Dec 31<br>2005                              | 20c. Location · City or Town, State  Beltsville, Maryland               |
| permit. Pa<br>Departmen<br>Important:<br>any injury   |                  | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facility<br>Cremation and Funera                           | ıl Alterna                                  | atives  |
| 20 E 2 9  |                  | Lunda Sue Retter MO1443  | 717 Green Pastures   | Drive Ba                                    | altimore, Maryland  |
|   |                  | 23a. Part1. Inter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.   |  |   | Open and Deat   |
| hysician<br>/Medical  |                  | resulting in death)  | RUAMORS (ELL (A)   | LLINONA                                     |   |
| Examiner  |                  | Due to (or as a consequence of):   |  |   |   |
| WARN!   | Je.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |   |   |
| nd<br>ransit  | Examiner         | that initiated events  |  |   |   |
| e be executed<br>sician end<br>burial-transit   | al Ex            | resulting in death) Last Due to (or as a consequence of):  |  |   |   |
| physicate to the the the the the the the the the the  |                  | d  |  |   |   |
| Ine law requires that the death certificate be execut. It has been signed by the attending physician end bage 2 should be detached for use as the burial-tran | Physician/Medic  |  | □Ectopic pregnancy □ Other (specify)   |   | 23d. Date of delivery<br>Month Day Year                                 |
| that the ed by detact   | Ph               | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.  | 23e. Did to                                 | baccoruse contribute to the cause of death:                             |
| uires that<br>signed t  | d by             |  | ,,   |   | es 2 □ No 3 □ Probably 4 □Unkno   |
| s been s  | Completed        |  |  | 24a. Was                                    | an 24b. Were autopsy findings availa                                    |
| The lay<br>te has   | mo               |  |  | autop<br>perfor                             | sy prior to completion of cause death? 2 No 1 Yes 2 No                  |
| Physician: The hysic cartificate har all director, page   | Be C             | 25. Was case referred to medical examiner?   | 26. Place of Dea   | th (Check only o                            |   |
| this ce<br>al dire  | ဥ                | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie   |  | ome 5 Aesid                                 | ence 6 DOther (Specify)   |
| Attending Price death.  actor: After the by the funeral   | Certification:   | 27. Manne: Death  1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \  | Work?<br>M 1 ☐ Yes 2 ☐ No  | 28d. Describe h                             | low injury occurred   |
| D 00 0  | Certiff          | 4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)   | treet, factory, office   | 28f. Location (S<br>City or Tow             | treet and Number or Rural Route Number,<br>rn, State)                   |
| rei Dlı<br>led in   | CD.              | 29a. Certifier (Check only (Check only Medical Examiner: On the basis of examination and/or in the basis of examination and the basis of examination and/or in the basis of examination and t | th occurred at the time, date and place<br>nvestigation, in my opinion, death occu | , and due to the or<br>rred at the time, or | cause(s) and manner as stated.  date and place, and due to the cause(s) |
| ne nospitel of<br>in 24 hours afte<br>he Funerel Dir<br>pletely filled in   | edic             | one) and manner stated.  |  |   | 29d. Date signed (Month, Day, Year)                                     |
| to the nospitel of Authoring Private in 24 hours affer death.  To the Funerel Directors After the completely filled in by the funeral                         | Medical          | 29b. Signature and title of certifier  | 29c. License number  |   |   |
| within 24 hours after   | Medic            | 29b. Signature and title of certifier  | D005991  |   |   |
| within 24 hours after to the Funerel Direction Completely filled in   | Medic            | 29b. Signature and title of certifier  30 Lame and 11 June 5 of person who completed cause of death (Item 23a) (Type   | D005991  |   |   |
| Y   |                  | 29b. Signature and title of certifier  30 Lame and 11 mes of person who completed cause of death (Item 23a) (Type  | D005991  |   | 12/30/05<br>linton Md 2073:   |
| within 24 hours after the Funerel Dir completely filled in  | te               | 29b. Signature and title of certifier  30 tame and autors of person who completed cause of death (item 23a) (Type  | D005991  |   |   |

|   |                  | 1 - For<br>State<br>Registrar  | State of Ma  | ryland      |                               | rtment of H<br>tificate of L                                      |                                | nd Men       |   | iene<br>.g. No. 0 0          | 5                          | 4245   | 55       |
|---|------------------|--|--|-------------|-------------------------------|---|--------------------------------|--------------|---|------------------------------|----------------------------|--|----------|
| Physic  | ian              | 1. Decedent's Name (First, Middle, Last)   | D - 1  |             | 11:                           | A   | ي.                             |              | Date of Deat<br>Month<br>EC             |                              | Year<br>005                | 3. Time of t                                 |          |
| /Medi   | cal              | 4a. Facility Name (If not institution, give s  | Robert   | Wl          | 11iam                         | Arcan   |                                |              | EC                                      | 4c. County o                 |                            | 9:55   | AW       |
| Exami   | ner              | Gilchrist  |  |             |                               |   | wson                           |              |   |                              |                            | imore  |          |
| Funeral<br>Director   |                  | 5. Social Security Number  013-32-1528  Usual Residence of Decedent  | 7. Age   | 61          | as <i>t birthday)</i><br>Yrs. | If Under 1 Year<br>Months Days                                    |                                | Min.         | Date of Birth<br>(Month, Day,<br>PR 17, | Year)<br>1944 Ma             | Cour                       | olace (State or<br>otry)<br>Chuset           | _        |
| yland   |                  | 10a. State 10b. County   |  | 10c. City   | , Town or Lo                  |   |                                |              |   |                              | 1                          | 0d. Inside City                              | y Limits |
| ith the Marylar<br>or 28e-f ehow  | ctor             | MD N/A   |  |             |                               | В   | altim                          | nore         |   |                              |                            | 1 X Yes                                      | 2 No     |
| with th   | Funeral Director | 10e. Street and Number 2819 Goodwood   | Poad   |             |                               | 10f. Zip Code   | 2121                           | /1           | 1                                       | 0g. Citizen of WI<br>US      |                            | ntry?  |          |
| ne 23   | era              |  | 12. Was Decedent E   | Ever in U.S | S. 13. V                      | Vas Decedent of Hi<br>Yes, specify Cuba                           |                                |              | Yes or No-                              | 14. Race                     | - Americ                   | an Indian,                                   |          |
| yidilid. Z. I.Z. 13-0030<br>build be filed within 72 hours after death with the Maryland<br>Mental hygiene.<br>arked other then "natural", or Items 23a or 28e-1 ehow<br>attc event, the Medical Exeminar must be notillied at  | þ                | 1 Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:  | lo          |                               | Yes, specify Cuba   | n, Mexican, I<br>Specify:      | Puerto Rica  | in, etc.)                               | Specify:                     | , White,                   | <sub>etc.</sub><br>ite                       |          |
| 72 hc   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)  |             | (Give                         | lent's Usual Occupa<br>kind of work done of<br>OO NOT use retired | turina most a                  | of working   |   | 16b. Kind of Bus             | iness/In                   | dustry                                       |          |
| within iene.  | dwo              | Elementary/Secondary (0-12)  | Coflege (1-4or 5-  | +)          |                               | lemarke   |                                |              |   | S                            | ale                        | s  |          |
| e filed<br>I Hygi<br>other  | 0                | 17. Father's Name (First, Middle, Last)  |  |             |                               |   |                                | s Name (Fi   | rst, Middle, I                          | Maiden Sumame                |                            |  |          |
| Menta<br>Menta<br>Menta<br>Menta<br>Menta<br>Menta<br>Menta<br>Menta<br>Menta<br>Menta<br>Menta   | To B             |  |  | rca         |                               |   |                                | lose         | Iren                                    |                              |                            |  |          |
| Vial<br>12 sh<br>h and<br>7 is m<br>traum   |                  | 19a. Informant's Name/Relationship (Ty)  |  | 0.10        |                               | g Address (Street a<br>. Galaxy                                   |                                |              |   |                              |                            |  | 66       |
| Healt<br>Healt<br>tem 2   |                  | Judy A. Desparo 20a. Method of Disposition   | 15, 5151   | 20b, PI     | lace of Dispos                | sition (Name of   |                                | Apt. 2       |   | Sapulp & 20c. Location - C   |                            |  | 30       |
| Pages<br>bent of<br>nt: If it   |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State  |             |                               | natory or other place<br>matory, I                                |                                | 2/30/0       | 05                                      | Baltim                       | ore                        | , MD   |          |
| parmit. Pages 1 and 2 should be filed within permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then eny injury or other traumatic event, Ins.M. DRGs.   |                  | 21. Signature of Funeral Service License   | George   | MacNa       | estimate in                   | Name and Address<br>Cremation<br>299 Free                         | s of Faculty<br>On So<br>deric | ciet<br>k ko | y of<br>ad E                            | Maryla<br>saltimo            | nd,                        | Inc.   | 1228     |
|   |                  | 23a. Part1. Enter the disease, or compli<br>shock, or heart failure. List only or                            | cations that caused<br>e cause on each lin                 | the death   | . Do not ente                 | er the mode of dying  | g, such as ca                  | ardiac or re |   |                              | U.C.                       | Approximate<br>fnterval Betw<br>Onset and De | reen     |
| Physician   |                  | Immediate Cause (Final disease or condition resulting in death)  | Colo   |             | cano                          | e/  |                                |              |   |                              | - (                        | mont   | 7/5      |
| /Medical<br>Examiner  |                  |  | Due to (or as a  | a consequ   | uence of):                    |   |                                |              |   |                              | ,                          |  |          |
|   | je.              | Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or Injury | Due to (or as a  | s consequ   | iente offr                    |   |                                |              |   |                              |                            |  |          |
| icate be executed physician and sthe burial-transit   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                                      | -  |             |                               |   |                                |              |   |                              | 4                          |  |          |
| be exe  | E                | resulting in deathy cast   | Due to (or as a  | a consequ   | ience of):                    |   |                                |              |   |                              |                            |  |          |
| ficate<br>t physics the   | edicai           | d  |  | -           | 77000700                      |   |                                |              |   | - In the second              |                            |  |          |
| uies that the death certifications that the altending properties of detached for use as It  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant 2  | 3c. ff yes, outcome o                                      |             |                               | Ectopic pregnancy   |                                |              |   | 23d. Date                    |                            | -  |          |
| s death   | sicia            | in the past 12 months?   | 4☐Pregnant at t  |             |                               | Other (specify)   |                                |              |   | Mont                         | h                          | Day Ye                                       | ear      |
| hat the d by t  | Phy              | 9 ☐ Unknown  Part II. Other significant conditions con   |  | it not resu | ulting in the ur              | nderlying cause give  | an in Part I                   |              | 23e. Did tob                            | pacco use contrib            | oute to th                 | ne cause of de                               | ath?     |
| signe   | d by             | arti. Ottor significant solications con  | thouting to doubt bu                                       | 111011000   | inting in the di              | idonying seess give   | AT 111 Q11 1.                  |              |   | _                            | Prob                       |  | nknown   |
| w requires been significant to the state of | Completed        |  |  |             |                               |   |                                |              | 24a. Was a                              | n 24b. W                     | ere auto                   | psy findings a                               | vailable |
| The la  | шо               |  |  |             |                               |   |                                |              | autops<br>perform                       | y<br>mpd? de<br>2.0∡No 1.0   | or to cor<br>ath?<br>] Yes | mpletion of cal<br>2□ No                     | TSE OI   |
| sician: The law<br>scentificete has b<br>firector, page 2 s   | Be               | 25. Was case referred to medical examiner?   |  |             |                               | 101   | -                              | of Death (CI | heck only on                            | <b>5</b>                     |                            |  | 4        |
| ding Physician: The I<br>ding Physician: The I<br>h.<br>After this certificete ha<br>funeral director, page   | 2                | 1 ☐ Yes 2 No   | ospitaf: 1  fnpatier                                       |             | ER/Outpatien<br>28b. Time of  |   | 4 LI Nurs                      |              | 5 Reside                                | ow injury occurre            |                            | n hosp                                       | up       |
| ding<br>th.<br>After  | tion             | Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day                         | Year)       | Injury                        | 28c. Injury<br>Work   | (?`<br>Yes 2∐No                |              | 50001150110                             | anjuny occurre               | •                          |  |          |
| al or Atter<br>s after dea<br>I Director<br>d in by the   | Certification;   | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of fnju<br>building, etc                        | iry - At ho | me, farm, stre                | eet, factory, office  |                                |              | Location (St.<br>City or Town           | reet and Number<br>n, State) | or Rura                    | il Route Numb                                | er,      |
| To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the  | Medical C        | 29a. Certifier (Check only one) 2 Medical Examin   | sician: To the best oner: On the basis of and manner state | examinat    |                               |   |                                |              |   |                              |                            |  |          |
| To the To the To the Comp   | X                | 29b. Signature and title of certifier  | 0.   |             |                               | 29c. License  |                                | 0            |   | 9d. Date signed              |                            |  |          |
| 6   |                  | A Car  |  | W)          |                               | NS  | 050                            |              |   | worms                        | 05 0                       | 27 000                                       | )ú       |
| 7   |                  | AMEN CHALLI  | mpleted cause of de  | 66          | or N-                         | Charle  | . St                           | BAC          | nno                                     | Dooms                        | 120                        | 4  |          |
| St<br>Regist  | ate              | 31. Date filed (Month, Day, Year)  JAN 0 3 20  | 32. Registra   | rs Signat   | ture                          | aches   |                                |              |   |                              |                            |  |          |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#26, perMD?G851,1-3-05 II

|   |                      | State of Marylar   |                        | artment of Heal<br>rtificate of Dea  |                                  |  | 2005                              | 42456  |
|---|----------------------|--|------------------------|--|----------------------------------|--|-----------------------------------|--|
| Physici   | _                    | 1. Decedent's Name (First, Middle, Last)  Elizabeth  |                        | Allen  |                                  | 2. Date of Death<br>Month                                    | Day Year<br>r 30,2005             | 3. Time of Death 4:15 A                                    |
| /Medio<br>Examin  |                      | 4a. Facility Name (If not institution, give street and number) 7814 North Cove Road  |                        | 4b. City, Town, or Loca  |                                  | ресешье  | 4c. County of Dea                 |  |
| Funeral<br>Director   |                      | 5. Social Security Number  219-18-5120  Usual Residence of Decedent  6. Sex 1 M 2 F 7. Age (In yrs.  | last birthday)<br>Yrs. | If Under 1 Year If U   |                                  | 8. Date of Birth<br>(Month, Day, Y<br>Sept. 13               | ear) 9. Bird                      | thplace (Slate or Foreigr<br>ountry)<br>.aware             |
| Maryland  | ctor                 |  | ty, Town or Lo         | cation   | Edgen                            | nere   |                                   | 10d, Inside City Limits<br>1 ☐ Yes 2X No                   |
| with the  | Director             | 10e. Street and Number 7814 North Cove Road  |                        | 10f. Zip Code  | 21219                            |  | . Citizen of What Co<br>United St | ,  |
| is 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or itame 23a or 28a-f ehow other treumatic event, the Madical Examiner matches in pulling at | by Funeral           | 11. Marital Status  12. Was Decedent Ever in U Armed Forces?  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:  |                        | Was Decedent of Hispan<br>f Yes, specify Cuban, Me                         |                                  |  | 14. Race - Ame<br>Black, Whit     | erican Indian,   |
| rithin 72 hounder.<br>The matural   | Completed t          | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  | (Give                  | dent's Usual Occupation<br>kind of work done during<br>DO NOT use retired) | most of worki                    | ng 16  | b. Kind of Business               | /Industry  |
| oe filed w<br>lal Hygier<br>d other th  | Be Cor               | 7 Years<br>17. Father's Name (First, Middle, Last)   | HO                     | memaker  |                                  | (First, Middle, Ma   |                                   | ie   |
| should but nd Ment  | To                   | Emerson Tarburton  19a. Informant's Name/Relationship (Type, Print)  | 19b. Mailir            | ng Address (Street and N   |                                  | ces Nagen  |                                   | Zip Code)  |
| t and 2<br>Health a<br>Im 27 is   |                      | Barbara F. Cooper (Daughter)  20a. Method of Disposition 20b. F  |                        | 5 East Ave.  |                                  | mere, Mar  | yland 21<br>c. Location - City or | .219   |
| permit. Pages 1 and 2 Department of Health s important: if Item 27 is any injury or other tre   |                      | ® Burial 2 □ Cremation 3 □ Bernoval from State   | cemetery, cren         | natory or other place)<br>11 Mem. Gdn                                      | [                                |  | Middle Ri                         |  |
| permit. Departr importu any inju  |                      | 21. Signature of Funcial Segrice Licensee  |                        | Name and Address of Funda-Ruck Fu  |                                  |  |                                   | inc<br>21222   |
| Physician /Medical Examiner transit the pnia-transit  | al Examiner          | 23a. Part1. Enter the disease, or complications that disease the deal shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consection of the condition of | quence of):            | er the mode of dying, such   | de as cardiac co                 | at l   |                                   | Approximate<br>Interval Between<br>Onset and Death         |
| death certifi<br>e attending  <br>id for use as   | by Physician/Medical | d  | ıl death 3 ☐           | Ectopic pregnancy Other (specify)  |                                  |  | 23d. Date of del<br>Month         | ivery<br>Day Year  |
| sign<br>d be  | ed by Ph             | Part II. Other significant conditions contributing to death but not res  | sulting in the ur      | nderlying cause given in I   | Part I.                          | 23e. Did tobac   | co use contribute to              | the cause of death?  |
|   | Completed            |  |                        |  |                                  | 24a. Was an autopsy performe                                 | prior to death?                   | utopsy findings availab<br>completion of cause of<br>2  No |
| director, page  | To Be                | 25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 D   | ER Outpation           | Othor  |                                  | ne 5 <b>2</b> Residenc                                       | e 6 Other (Spe                    | cify)  |
| i o the hospital of Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i   | Certification:       | 27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day Year)  1 Note of Injury (Month, Day Year)  28b. Place of Injury - At homicide  28b. Place of Injury - At homicide  28c. Place of Injury - At homicide  |                        | Work?<br>M 1 ☐ Yes   | 2 🗆 No                           | 28d. Describe how<br>28f. Location (Stree<br>City or Town, S | t and Number or Ru                | ural Route Number,   |
| Hospital C<br>24 hours af<br>Funeral Di<br>stely filled in  | Medicai Cer          | Check only one)  Check only one)  Check only one)  Check only one)  Check only one)  Check only one)   | wiedge death           | n adoutted at the time da<br>vestigation, in my opinion                    | ite and place; it, death occurre | and dua to the caused at the time, date                      | and place, and due                | etalso<br>to the cause(s)                                  |
| To the within ? To the comple   | Mec                  | 29b. Signature and title of certifier  | W                      | 29c. License num   | 1ber 3                           |  | Date signed (Monti                |  |
| 07  | 18                   | 30. Name and address of person who completed cause of death (Iter  | m 23a) (Type,          | Print) Bla   | d #70                            | of Bal   | 1 sorte                           | N 212  |
| Sta   | _                    | 31. Date filed (Month, Day, Year) 32. Begistrar's Signa  | ature                  | antil 1  |                                  |  |                                   |  |

|                     |  |                     | 1 - For<br>State<br>Registrar  | State of M  | laryland                              |                   | artment of I                            |                | and Mental H                                    | ygiene<br>Reg. No  | UUU                        | 424                               | 57          |
|---------------------|--|---------------------|--|---|---------------------------------------|-------------------|---|----------------|---|--------------------|----------------------------|-----------------------------------|-------------|
| П                   | Dhoole   |                     | 1. Decedent's Name (First, Middle, L.  | ast)  |                                       |                   |   |                | 2. Date of E                                    |                    |                            | 3. Time o                         | of Death    |
|                     | Physici<br>/Medio  |                     | Dorothy Bowman   |   |                                       |                   |   |                | Dec.  | 31,                |                            | 8:15                              | РМ          |
|                     | Examir   |                     | 4a. Facility Name (If not institution, gi  | ve street and number  | )                                     |                   | 4b. City, Town, o                       | or Location of | of Death  | 4c.                | County of Dea              |                                   |             |
|                     |  |                     | Charlestown Ca:  |   |                                       |                   | Catons                                  |                |   | E                  | altimo                     | ore                               |             |
|                     | Funeral  |                     |  | Sex 7. A<br>1 ☐ M 2 【X】F  | ge (In yrs. la                        |                   | If Under 1 Year<br>Months Days          |                | 24 Hrs. 8. Date of B<br>Min. (Month, I          | irth<br>Day, Year) | 9. Bir                     | thplace (State ountry)            | or Foreign  |
|                     | Director   |                     | Usual Residence of Decedent  |   | 87                                    | Yrs.              |   |                | Min. (Month, L<br>Aug. 2                        | 2,19               | 18 Ne                      | w Ĵers                            | ey          |
|                     | land Dw  |                     | 10a. State 10b. County   |   | 10c. City,                            | Town or Lo        | cation                                  |                |   |                    |                            | 10d. Inside C                     | City Limits |
|                     | Many   | ō                   | Maryland Baltim  | ore   | Cato                                  | onsvil            | 10                                      |                |   |                    |                            |                                   | 2 No        |
|                     | 1 the  | rec                 | Maryland Baltim  10e. Street and Number  | 510   | Lac                                   | 2112 4 1 1        | 10f. Zip Code                           |                |   | 10g Citi           | zen of What Co             |                                   |             |
|                     | 3a or  | ٥                   | 719 Maiden Choice  | Lane BR 2   | 205                                   |                   | 21228                                   |                |   |                    | ed Sta                     |                                   |             |
|                     | hours after death with the Maryland<br>rurel', or tiems 23a or 28e-f show<br>at Examitmer must be notified at                                    | by Funeral Director | 11. Marital Status   | 12. Was Decedent  | Ever in U.S                           | 13. \             | Nas Decedent of H                       | Hispanic Orig  | gin? (Specify Yes or N<br>, Puerto Rican, etc.) | 10-                | 14. Race - Ame             | erican Indian.                    |             |
| 9                   | after<br>or ite  | Ē                   | 1 ☐ Never Married 2 ☑ Married  | Armed Forces  |                                       |                   | _                                       |                | , Puerto Rican, etc.)                           | 1                  | Black, Whit                | te, etc.                          |             |
| ဗ္ဗ                 | rei',  | l by                | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:  |                                       |                   | 1 ☐ Yes 2 🛣 No                          | Specify:       |   |                    | Specify: Wh                | ite                               |             |
| 5                   | 72 h   | Completed           | 15. Decedent's E<br>(Specify only highest gr   |   |                                       | 16a. Deced        | lent's Usual Occup<br>kind of work done | ation          | of working                                      | 16b. Ki            | nd of Business             | /Industry                         |             |
| 2                   | within 72<br>ene.<br>then "net   | mpl                 | Elementary/Secondary (0-12)  | College (1-4or  | 5+)                                   | life. L           | DO NOT use retire                       | d)             | g   |                    |                            |                                   |             |
| 7                   | filed v<br>Hygie<br>other t  |                     | 12 17. Father's Name (First, Middle, Las.  | 4   |                                       | Visua             | al Artist                               |                |   |                    | tistic                     |                                   |             |
| anc                 | m == 0 =   | Be                  | John B. Cutler   | 0   |                                       |                   |   | _              | r's Name <i>(First, Middl</i><br>. Cawston      | e, Maiden          | Sumame)                    |                                   |             |
| ž                   | 1 Me<br>nark<br>natic  | ို                  |  |   |                                       |                   |   |                |   |                    |                            |                                   |             |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked eny injury or other treumatic es ance.            |                     | 19a. Informant's Name/Relationship  Jacquelyn Campbel  |   | or                                    |                   |   |                | r or Rural Route Num                            |                    |                            |                                   | 21221       |
| e,                  | 1 and<br>Healt<br>em 2<br>ther   |                     | 20a. Method of Disposition   | - daugite   |                                       |                   | sition (Name of                         | eet A          | pt. 210, B                                      |                    |                            |                                   | 2123        |
| altimore,           | ages<br>if it  |                     | 1 ☐ Burial 2 🔀 Cremation 3 [   |   | cer                                   | metery, cren      | ratory or other place<br>rematory       | ce)            | /3:/2006  |                    | cation - City or<br>imore, |                                   | n d         |
|                     | rtmer<br>rtent<br>rtent  |                     | `4 □Donation 5 □ Other (Speci  |   | Day                                   |                   |   |                | ·   |                    | •                          | _                                 | Па          |
| Ba                  | permi<br>Depa<br>Impo<br>eny iv  |                     | 21. Signature of Funeral Service Lice  | nsee  |                                       |                   |   |                | Hubbard F                                       |                    | •                          |                                   |             |
|                     |  |                     | 23a. Part1. Enter the disease, or con  | rations that sauce  | d the death                           | 41                | 07 Wilke                                | ns Ave         | enue, Balt                                      | imore              | , Maryl                    | Land 21                           |             |
| 8760,               | law requires that the death certificate be executed  Expanding by the attending physician and 2 should be detached for use as the burial-transit | dical Examiner      | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as  b. Due to (or as  c. Due to (or as  d.                | bra (<br>s a conseque<br>s a conseque | ence of):         | ular A                                  | -ccid          | ent   |                    |                            | Interval Bet<br>Onset and         | Death       |
| 9                   | ng ph  | Med                 | IF FEMALE:   |   | <del></del>                           |                   |   |                |   | 1                  |                            |                                   |             |
| O. Box              | at the death certifi<br>by the attending prached for use as  | hysiclan/Me         | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No  | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown | 2 Fetal d                             | leath 3 🗌         | Ectopic pregnancy<br>Other (specify)    | 1              |   | 2                  | 3d. Date of deli<br>Month  | *                                 | Year        |
| J.                  | that   | by PI               | Part II. Other significant conditions  | contributing to death b   | out not result                        | ing in the un     | derlying cause giv                      | en in Part I.  | 23e. Did  | tobacco us         | se contribute to           | the cause of d                    | leath?      |
| <u>d</u> S          | uires<br>n sign  | d<br>D              | Atrial Fibrili   | ation   |                                       |                   |   |                | 10  | Yes 2              | ]No 3□Pro                  | obably 4 🗹                        | Inknown     |
| Hecords,            | w require<br>been si<br>should b   | lete                | Dysphagia  |   |                                       |                   |   |                | 24a. Was  | 20                 | 24h Woro au                | topou findingo                    | avadable.   |
|                     | φ <u>-</u> - 9   | Completed           | •  |   |                                       |                   |   |                | auto  |                    | prior to death?            | topsy findings<br>completion of c | ause of     |
| Vital               | icien: Th<br>certificate<br>ector, pag   | Ö                   | Sculle Ane 25. Was case referred to medical  | mia   |                                       |                   |   | 00 81          | 1 Yes   |                    | 1 🗆 Yes                    | 2 □ No                            |             |
|                     |  | OB                  | examiner?<br>1 ☐ Yes 2 ☑ No  | Hospital:   | ent 2 TE                              | -<br>R/Outpatient | 3 DOA Oth                               |                | of Death <i>(Check only</i> sing Home 5 Res     |                    | CO11                       |                                   | 1           |
| Ö                   | g Physer this eral di  | Ŀ                   | 27. Manner of Death  | 28a. Date of Inju   | ıry 2                                 | 8b. Time of       | 28c. Injun                              | y at           | 28d. Describe                                   |                    |                            | city)                             |             |
| ō                   | Attending or death. ector: After by the funer  | atlo                | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio   | ( <i>Month, D</i> a   | y rear)                               | Injury            | Worl<br>M 1 □                           | k?<br>Yes 2⊟N  | lo  |                    |                            |                                   |             |
| DIVISION            | or Attendate death Director: in by the   | Certification;      | 3 Suicide 6 Could not be determined  | e 28e. Place of Inj   | ury - At hom                          | ie, farm, stre    | et, factory, office                     |                | 28f. Location (                                 | Street and         | Number or Ru               | ral Route Num                     | ber,        |
| 5                   | s after si Dir   | Sert                | 4 _ Northcide  | building, et  | с. (Бресіту)                          |                   |   |                | City or To                                      | wn, State)         |                            |                                   |             |
|                     | To the Hospitei or At within 24 hours after of To the Funerei Direct completely filled in by   |                     | 29a. Certifier 1 Certifying Pt (Check only 2 Medical Example)  | nysician: To the best   | of my knowle                          | edge, death       | occurred at the tim                     | ne, date and   | place, and due to the                           | cause(s) a         | and manner as              | stated.                           |             |
|                     | he H<br>in 24<br>he Fi<br>plete  | edical              | one)   | and manner st   | ii examinatio                         | n and/or inv      | estigation, in my o                     | pinion, death  | occurred at the time,                           | date and           | place, and due             | to the cause(s                    | )           |
|                     | To t<br>com  | Σ                   | 29b. Signature and title of certifier  | 2   |                                       |                   | 29c. License                            | e number       |   | 29d. Date          | signed (Month              | n, Day, Year)                     |             |
|                     |  |                     | De seen L  | owlin   | mo                                    |                   | 144                                     | 37             | 7   | 1/11               | 06                         |                                   |             |
|                     | nn l   |                     | 30. Name and address of person who   | completed cause of  | leath (Item 2                         | 3a) (Type, F      | Print)                                  |                |   |                    | الر ک                      |                                   |             |
|                     | JU.  |                     |  | mo 711  | Maid                                  | er ch             | wice L                                  | ine.           | Cutensvil                                       | 6 1                | MD 2                       | 1228                              |             |
|                     | Sta  |                     | 31. Date filed (Month, Day, Year)  |   | ar's Signatur                         | re                |   |                |   | 1                  |                            |                                   |             |
|                     | Registra   | ar                  | JAN 0 3 21   | 006   | ar's Signatur                         | 1 Sa              | and I                                   |                |   |                    |                            |                                   |             |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 104 AM Virginia Upton Utranson 24 Byrd 05 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cheverly Prince Georges Prince Georges Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 7, 192 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 25€ F 79 Yrs. 577-32-9096 Director 1926 Washington, D.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow traumatic event, the Medical Examiner must be notified at Maryland Prince Georges Bowie 1- Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 7219 High Bridge Road 20720 United States or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be tiled within 72 hours atter d. Department of Heelth and Mental Hygiene. Importent: if Item 27 ie marked other than "neturel", or Item eny injury or other traumatic event, the Medical Exemperations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Pathology Laboratory Technician Hospital Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Patongall Upton Elizabeth Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce F. Byrd/ Son 7219 High Bridge Road, Bowie, MD 20720 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State West Arundel
Crematory or other place) 1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State Odenton, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** SETTLE SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner the attending physicien and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has Sa wal and Right heal 2 No Dearlytra Division of Vital u(cer 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death.
To the Funerel Director: Atter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MS 4203 Queensbuy Red Hyatho. He MID 2078 DEVORE 31. Date filed (Month, Day, Year) State JAN 0 3 2006 Registrar

|   |  |                  | 1 - For<br>State<br>Registrar   | State of Marylan   | d / Depa               | artment  | of Health and of Death   | l Mental Hy                 | giene<br>Reg. No | UUU                    | 4245                                    | 9     |
|---|--|------------------|---|--|------------------------|--|--|-----------------------------|------------------|------------------------|---|-------|
| S DH  | ysici  | àn               | 1. Decedent's Name (First, Middle, Las  | •  |                        |  |  | 2. Date of De<br>Month      | eath<br>Day      |                        | 3. Time of Dea                          |       |
|   | Medic  |                  | Arthur Gorman Bak   |  |                        |  |  | 12                          | 30               | 2007                   | 07091                                   | M     |
| E   | kamin  | er               | 4a. Fecility Name (If not institution, give   | 11   | T                      | n  | own, or Location of De   | ath                         |                  | County of Dea          |   |       |
|   |  |                  | 5. Social Security Number 96. S   | 4 RE 1705 DI<br>9x, 7. Age (In yrs. 1  | ast birthday)          | If Under 1   | SedA/e<br>Year If Under 24 H   | rs. 8. Date of Bi           | rth .            | 34/ Ji 1               | thplace (State or Fo.                   | reian |
|   | neral<br>ector                                   |                  |   | MM 2□F 56  | Yrs.                   |  | Days Hours Mi  |                             | 01               |                        | Itimore,                                | îD    |
| D   |  |                  | Usual Residence of Decedent   |  |                        |  |  | 10                          |                  |                        |   |       |
| arylar  | 曹  | L_               | 10a. State 10b. County  |  | , Town or Lo           |  |  |                             |                  |                        | 10d. Inside City Li                     | _     |
| Se M  | ctifis   | ecto             |   | re County Pa   | rkvill                 |  |  | 1                           |                  |                        |   | 3140  |
| with t  | 3  | Funeral Director | 10e. Street and Number  |  |                        | 10f. Zip C   |  |                             | -                | izen ol What C         |   |       |
| eath  | Inline   | era              | 7826 Daniels Ave.   | 12. Was Decedent Ever in U.  | S 13 V                 | Was Decede   | 21234  | (Specify Yes or N           |                  | nited S                |   |       |
| fter d  | ice  | Fu               | 1 Never Married 2 Marned  | Armed Forces?<br>1 □ Yes 2Ã No   |                        |  | nt ol Hispanic Origin?<br>y Cuban, Mexican, Pui<br>-   | erto Rican, etc.)           |                  | Black, Whi             |   |       |
| ours a  | Exe  | by               | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:   |                        | 1 □ Yes 2  | No Specify:  |                             |                  | Specify: V             | hite                                    |       |
| iii (C K I K I S-0030<br>be filed within 72 hours after death with the Maryland<br>Hylygiene.<br>do other than "natural", or items 23a or 28a-f show  | 25   | Completed        | 15. Decedent's Ed<br>(Specify only highest gra  | lucation<br>de completed)  | 16a, Deced             | dent's Usual<br>kind of work   | Occupation done during most of w   | rorkina                     | 16b. K           | ind of Business        | /Industry                               |       |
|   | W S  | mpi              | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                        |  | done during most of w<br>retired)  |                             |                  | I 1 1                  | C - C 1                                 | ,     |
| led v<br>tygie  | 필  |                  | 12<br>17. Father's Name (First, Middle, Last)   | n/a  | Se                     | arood  | Packer   | ame (First, Middle          |                  |                        | e Seafood                               | -     |
| d be fundal b   | <b>&gt;</b>                                      | Be C             | Arthur Gorman Bak   | or Sr  |                        |  |  | Marie Bu                    |                  | ,                      |   |       |
| should Me   | mati   | မ                | 19a. Informant's Name/Relationship  |  | 19b. Mailin            | na Address (   | Street and Number or   |                             |                  |                        | Zip Code)                               |       |
| NG 2 state of the | rtrau  |                  | Thelma Marie Lamb   |  |                        |  |  | rkville,                    |                  |                        | 1234                                    |       |
| s 1 ar<br>f Hea   | othe   |                  | 20a. Method of Disposition  | 20b. P   | lace of Dispo          | The second secon | A STATE OF THE STA | Date                        |                  | cation - City o        |   |       |
| Page<br>lent o  | ry or  |                  | 1 ☐ Burial 2√☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)   | Removal from State Eval  |                        |  | Chapel Jan.  | 02,2006                     | For              | est Hil                | 1, Maryla                               | nd    |
| Datimore, Individual ZIZIS-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural: or items 23a or 28a-f show   | sny inju<br>once.                                |                  | 21. Signature of Funeral Service Licer  | seef gair  | Pr 3                   | Name and<br>aceful<br>25 Yor   | Address of Facility<br>Alternati<br>k Road Ti  | ves Fune                    | ral&             | Cremati                | on Ctr.,P                               | .A.   |
| 5   |  |                  | 23a. Part. Enter the disease or com<br>shock, or heart lailure. List only                                   | plications that caused the death   |                        |  |  |                             |                  | runa z                 | Approximate<br>Interval Between         |       |
| Physi   | cian   |                  | tmmediate Cause (Final disease or condition   | Halaa a sa maa d   |                        |  |  |                             |                  |                        | Onset and Deat                          |       |
| /Med  | lical  | 1                | resulting in death)   | a. Due to (or as a consequ   | ,                      |  |  |                             |                  |                        |   |       |
| Exam  | iner   |                  | Sequentially list conditions  | b. Respirato Unit (or as a consequence L   | Ry F                   | FAILU  | Re   |                             |                  |                        |   |       |
| D D   | sit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due tof(or as a consequ  | uen of):               | rated of   |  |                             |                  |                        |   |       |
| be executed   | Il-tran  | хап              | that initiated events<br>resulting in death) Last   | c. Due to (or s a consequ  | ence of):              | A.R.C.I.   | -om  |                             |                  |                        |   |       |
| e be e  | buris  | caiE             |   | d  |                        |  |  |                             |                  |                        |   |       |
| ifficate  | as the   |                  | 1   | . u.   |                        |  |  |                             |                  |                        |   |       |
| h cert  | esn  | Physician/Med    | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal                                  |                        | Ectopic pred   | Inancy   |                             |                  | 23d. Date ol de        | ,                                       |       |
| deal deal   | of be  | sicia            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4 □ Pregnant at time of de<br>9 □ Unknown  |                        | Other (spec  |  |                             |                  | Month                  | Day Year                                |       |
| of the  | etech  | Phy              | 9 Unknown   |  | Jaine in all a         | - 4 - 1 - 1  |  | 222 Did                     |                  |                        | - 4 1 1                                 | 2     |
| ires th   | should be deteched for use as the burial-transit | d by             | Part II. Other significant conditions of  | ontributing to death but not rest  | liting in the ur       | nderlying cau  | ise given in Part I.   |                             |                  | . ^                    | o the cause ol death<br>robably 4 □Unkn |       |
| he law requires   | shoul  | Completed        |   |  |                        |  |  | 24a. Was                    |                  |                        | utopsy findings avail                   |       |
| he tay  | 99 2   | m C              |   |  |                        |  |  | auto                        | psy<br>ormed?    | prior to death?        | completion of cause                     |       |
| VICAL<br>ician: T<br>sertificat   | or, pa   | a                | 25. Was case relerred to medical  |  |                        |  | 26 Place of D  | 1 ☐ Yes<br>eath (Check only |                  | 1 ∐ Ye                 | s 2□ No                                 |       |
| ysicia  | direct   | To B             | examiner?<br>. 1 ☐ Yes 2 2 No   | Hospital: 1 Inpatient 2  | ER/Outpatien           | t 3 DOA  | Other  | Home 5 ☐ Res                |                  | 6 □Other (Spe          | ecify)                                  |       |
| 9 F 9   | neral  |                  | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury | 280  | c. Injury at<br>Work?  | 28d. Describe               |                  |                        | //                                      |       |
| Attending at death.   | ne fur   | atic             | 1 Natural 5 Pending investigation   |  | ,,                     | М  | 1 ☐ Yes 2 ☐ No   |                             |                  |                        |   |       |
| or Atte   | n by t   | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Injury - At ho<br>building, etc. (Specify                                  | me, larm, str          | eet, lactory,  | office   | 281. Location<br>City or To |                  |                        | ural Route Number,                      |       |
| pital o   | led  |                  | 29a, Certifier 1 Certifying Ph  |  | L. Serie Carrier       | e servicio e rea   | and allow taken was and  | Windows and account         | 0.00.000.000     | Other and the transfer | on Wall Co.                             |       |
| DIVISION OF VICE INCIDENCE TO THE MECOLOGY, P.O. BOX 00/<br>To the Mepital or Attending Physician: The law requires that the death cartificate<br>within 24 hours after death.  | etery  | edical           | (Check only one)  | ysician: To the best of my know<br>niner: On the basis of examinat<br>and manner stated. | ion and/or inv         | vestigation, in  | n my opinion, death oc   | curred at the time          | , date and       | I place, and du        | e to the cause(s)                       |       |
| o the   | ldwos  | Me               | 29b. Signature and title of certifier   |  | ****                   | 29c. I   | License number   |                             | 29d. Da          | e signed (Mon          | th, Day, Year)                          |       |
|   |  |                  | 1 (houl B Klent   | history  |                        | 1)   | FS 0000  | )                           | 12/              | 38/05-                 |   |       |
|   | 0  |                  | 30. Name and address of person who  | completed cause of death (Item   | 23a) (Type,            | Print)   |  | 77-1-1-2-7                  | //-              | 1                      | 500                                     |       |
|   | 1  |                  | be Joseph Herech  | 120gly 9000  | ERM                    | c Klin   | Square   | DE BA                       | 1Tim             | ORE /                  | 1 3123                                  | 2     |
| R   | Sta<br>egistr                                    |                  | 31. Date liled (Month, Day, Year) JAN 0 3 20  | Registrar's Signal   | ше                     | also !   | U  |                             |                  |                        |   |       |

|          |   |                | 1 - For<br>State<br>Registrar  | Sta                            | ate of Ma   | ıryland /                    |                   | artment of H  |                                    | and Me                       | ntal Hy                            | giene<br>Reg. No         | 7 11 11 1                              | 1 42                        | 2460                      |
|----------|---|----------------|--|--------------------------------|---|------------------------------|-------------------|---|------------------------------------|------------------------------|------------------------------------|--------------------------|--|-----------------------------|---------------------------|
|          | Physici   | an             | Decedent's Name (First, Midd   | le, Last)                      |   |                              |                   |   |                                    | 2                            | Date of De                         | aath<br>Da               | y Yea                                  |                             | ne of Death               |
|          | Physici<br>/Medio   |                | KATHRYN  | KB                             | REWE  | R                            |                   |   |                                    | D                            | CEMBE                              |                          |  | 5 12                        | 40 PM                     |
|          | Examir  |                | 4a. Facility Name (If not institution  |                                |   |                              |                   | 4b. City, Town, or  | Location of                        | of Death                     |                                    | 4c                       | . County of De                         | ath                         |                           |
|          |   |                | 1916 ROLLIN  | GWOO                           | DAD   |                              |                   | CATONS  | ILLE                               | 9                            |                                    | 8                        | BALTIN                                 | MORE                        |                           |
| ı        | Funeral<br>Director   |                | 5. Social Security Number 219–18–4359  | 6. Sex<br>1 ☐ M 2              | -   | (In yrs. last b              | irthday)<br>Yrs.  | If Under 1 Year<br>Months Days                            | If Under<br>Hours                  | Min.                         | Date of Bir<br>(Month, Da<br>Ct. 1 | th $y$ , $Year$ )        | 9. E<br>25 So                          | Country)                    | ate or Foreign<br>rolina  |
|          | D >   |                | Usual Residence of Decedent  |                                |   | 10- Oir T                    |                   |   |                                    |                              |                                    |                          |  |                             |                           |
|          | death with the Maryland<br>ms 23a or 28a-f ehow<br>rmust be notified at   | _              | 10a. State 10b. Count  |                                |   | 10c. City, Tov               | vn or Lo          |   |                                    |                              |                                    |                          |  |                             | de City Limits            |
|          | Ba-f  | Director       |  | imore                          |   |                              |                   | Catonsv   | ille                               |                              |                                    |                          |  | 10                          | Yes 2001No                |
|          | in or 2   | i i            | 10e. Street and Number   |                                |   |                              |                   | 10f. Zip Code   |                                    |                              |                                    | 10g. Cit                 | izen of What                           | Country?                    |                           |
|          | ath v   | Ta l           | 1916 Ro11  |                                |   |                              |                   | 2   | 1228                               |                              |                                    |                          | USA                                    |                             |                           |
|          | be filed within 72 hours after death with the Marylan Hydione.  4 other than "natural; or items 23a or 28a-1 show event, the Madical Examinat must be notified at                                     | by Funeral     | 11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce                 | ned 1                          | /as Decedent E<br>rmed Forces?<br>□Yes 2/03/N<br>Yes, Give<br>ear or Dates: |                              |                   | Was Decedent of Hi<br>If Yes, specify Cuba<br>1□ Yes 2√No | spanic Origin, Mexican<br>Specify: | gin? (Specif<br>, Puerto Ric | y Yes or No<br>an, etc.)           | )-                       | 14. Race - Ar<br>Black, Wi<br>Specify: | nite, etc.                  | n,                        |
| 5        | 2 ho  | ted            | 15. Decede   | nt's Education                 | 1   | 16a                          | . Dece            | dent's Usual Occupa                                       | ation                              |                              |                                    | 16b. K                   | ind of Busines                         | ss/Industry                 |                           |
| <u> </u> | 7 circ<br>r o   | Completed      | (Specify only highs Elementary/Secondary (0-12)                              |                                | ollege (1-4or 5-  |                              | (Give             | kind of work done of DO NOT use retired                   | turing most<br>)                   | of working                   |                                    |                          |  | - Masony                    |                           |
| <u>'</u> | filed within<br>Hygiene.<br>Ither than "<br>ant, the Me.  | E              | 10   | C                              | ollege (1-401 5-  |                              | ffi               | ce Manage   | r                                  |                              |                                    | Wi                       | re Manu                                | ıfactu                      | rer                       |
| 2        | e filed within at Hygiene. other than 'vent, the Me   | BeC            | 17. Father's Name (First, Middle   | Last)                          |   | '                            |                   |   | 18. Mothe                          | r's Name (F                  | irst, Middle                       |                          |  |                             |                           |
|          | id be<br>ked o  | To B           | Adolphe Kop  | pe1                            |   |                              |                   |   |                                    | Edna                         | Gott                               | va 11                    | es                                     |                             |                           |
| _        | is 1 and 2 should be of Health and Mental item 27 is marked (other traumatic even   | -              | 19a. Informant's Name/Relation   | ship <i>(Type, Pi</i>          | rint)   | 19                           | o. Mailir         | ng Address (Street a                                      | and Numbe                          | r or Rural R                 | oute Numb                          | er. City o               | or Town, State                         | . Zip Code)                 |                           |
| _        | and 2<br>salth a<br>n 27 is   |                | Marcy Graf - Ni  | ece                            |   |                              |                   | Brookhave   |                                    |                              |                                    | -                        |  |                             |                           |
| 3)       | Hea<br>Hea<br>tem<br>othe   |                | 20a. Method of Disposition   |                                |   |                              |                   | sition (Name of<br>natory or other place                  |                                    | Date                         |                                    |                          | ocation - City                         |                             | е                         |
| 2        | ages<br>ant of<br>t: ff<br>y or   |                | 1 Burial 2 Cremation   |                                | al from State   | 1                            |                   |   |                                    | 1 / 2/                       | 006                                |                          |  |                             |                           |
|          | rtme<br>ritan<br>njur   |                | 4 □Donation 5 □ Other ( 21. Signature of Euperal Service                     |                                | 7-2   | Metro                        |                   | ematory I<br>. Name and Addres                            | ,                                  | 1-4-2                        | 006                                | ват                      | timore                                 | , Mary                      | Tand                      |
| ğ<br>0   | permit. Pages: Deportment of Himportant: if ite any injury or of once.  |                | Cenn   | al                             | all   |                              | W:                | itzke Fun<br>530 Edmon                                    | eral<br>dson                       | Home (<br>Avenu              |                                    |                          | ville,<br>ville,                       | Inc<br>MD 21                | 228                       |
|          |   |                | 23a. Part1. Enter the disease, of shock, or heart failure. Lis               | r complication<br>only one cau | ns that caused to   | the death. Do                | not ent           | er the mode of dying                                      | g, such as                         | cardiac or re                | espiratory a                       | rrest,                   |  | Approx                      | imate<br>Between          |
| F        | hysician  |                | Immediate Cause (Final disease or condition                                  |                                | PECDI   | RATO                         | RY                | FAILL   | IRE                                |                              |                                    |                          |  | Onset a                     | and Death                 |
|          | /Medical  |                | resulting in death)  |                                | Due to (or as a   |                              |                   |   | _                                  |                              |                                    |                          |  | Cree                        |                           |
|          | Examiner  |                | Sequentially list conditions,  |                                | MYEL  | DYSE                         | LA                | STIC "  | 34N.                               | NOAD                         | IE                                 |                          |  | OUE:                        | TEAR.                     |
|          | n =   | ner            | if any, leading to immediate cause. Enter Underlying                         |                                | Due to (or as a   | consequence                  | of):              |   |                                    |                              |                                    |                          |  |                             |                           |
|          | nd  | Examiner       | that initiated events  | c.                             |   |                              |                   |   |                                    |                              |                                    |                          |  |                             |                           |
| 5        | icate be executed<br>physicien and<br>s the burial-transit  | E              | resulting in death) Last   |                                | Due to (or as a   | consequence                  | of):              |   |                                    |                              |                                    |                          |  |                             |                           |
| 00/0     | ysic<br>he bu   | dical          |  | d.                             |   |                              |                   |   |                                    |                              |                                    |                          |  |                             |                           |
|          | ≘ ⊘ਾਗ ∣   | (D)            | IF FEMALE:   |                                |   |                              |                   |   |                                    |                              |                                    |                          | -                                      |                             |                           |
| 5        | Attending Firstician: The taw requires that the beam certificate and described that this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1[<br>4[                       | yes, outcome o<br>□Live birth 2<br>□Pregnant at t<br>□Unknown               | Fetal death                  |                   | Ectopic pregnancy Other (specify)                         |                                    |                              |                                    | 2                        | 23d. Date of d<br>Month                | elivery<br>Day              | Year                      |
| Ĭ        | mar<br>ed by<br>deta  | /Ph            | Part II. Other significant conditi   | ons contributi                 | ing to death but  | t not resulting i            | n the ur          | nderlying cause give                                      | n in Part I                        |                              | 23e. Did to                        | obacco u                 | se contribute                          | to the cause                | of death?                 |
| ה<br>ב   | Sell sells  | d by           |  | NEM                            |   |                              |                   | ,···g   |                                    | 1                            | 10                                 |                          |  | Probably 4                  |                           |
| 5        | been<br>houl  | ete            | CITICOLO   | 0.010                          | .,  |                              |                   |   |                                    | -                            |                                    |                          |  |                             |                           |
| ۔ يَا    | has<br>has  | Completed      |  |                                |   |                              |                   |   |                                    |                              | 24a. Was<br>autor                  | sy                       | 24b. Were a                            | autopsy findi<br>completion | ngs available of cause of |
|          | cate  | ပိ             | <u></u>  |                                |   |                              |                   |   |                                    |                              |                                    | rmed?<br>2 No            | death?<br>1 ☐ Ye                       | s 2 No                      |                           |
|          | entifi<br>Betor   | Be             | 25. Was case referred to medica examiner?                                    |                                |   |                              |                   | T -   |                                    | of Death (C                  | heck only o                        | ne)                      |  |                             |                           |
| 5        | this of   | ဥ              | 1 ☐ Yes 2 ☐ No   | Hospita                        | 1 Linpatien   |                              | -                 |   | 4 LI Nur                           | sing Home                    | 5 Aresid                           | dence 6                  | 3 □Other (Sp                           | ecify)                      |                           |
|          | Miter   | -CO            | 27. Manner of Death 1 ☑Natural 5 ☐ Pendi                                     |                                | a. Date of Injury<br>(Month, Day  |                              | Time of<br>Injury | 28c. Injury<br>Work                                       | at<br>?                            | 28d                          | . Describe I                       | now injur                | y occurred                             |                             |                           |
| 2        | or: A   | cati           | 2 ☐ Accident invest  | gation                         |   |                              |                   | M 1 D Y   | ′es 2□N                            | lo                           |                                    |                          |  |                             |                           |
|          | s efter d<br>is Direct<br>id in by  | Certification: | 3 Suicide 6 Could 4 Homicide deter   |                                | e. Place of Injur<br>building, etc.   | y - At home, fa<br>(Specify) | arm, stre         | eet, factory, office                                      |                                    | 28f.                         | Location (S<br>City or Tox         | Street and<br>vn. State, | d Number or I<br>)                     | Rural Route I               | Vurnber,                  |
|          | very mospital of Attendary within 24 hours efter death.  To the Funeral Director: A completely filled in by the fu  | Medical        | 29a. Certifier 1 Certifyi  | Examiner. O                    | To the best of<br>in the basis of e<br>nd manner state                      | examination ar               | e, death          | occurred at the tim<br>restigation, in my op              | e, date and<br>inion, deatl        | place, and<br>h occurred a   | due to the<br>at the time,         | cause(s)<br>date and     | and manner a<br>place, and du          | as stated.                  | se(s)                     |
|          | withw<br>To the   | ž              | 29b. Signature and title of certifie   | ralva                          | rddy  | ne                           |                   | 29c. License  |                                    | 165                          | 1                                  |                          | e signed (Mor                          | -                           | · _                       |
|          | $\sigma$ ,  |                | 30. Name and address of person   | who complete                   | ed cause of de  | ath (Item 23a)               | (Typ2             |   |                                    |                              |                                    |                          |  |                             |                           |
|          | 1   |                | KHW-RUA  |                                |   |                              | Ju                | 20 0 0  | 021                                | ING 6                        | 20 0                               | 4 70                     | NEVII                                  | 180                         | 7 2/2                     |
|          | Sta   | te             | 31. Date filed (Month, Day, Year   | Á                              | 32. Registrar   | 's Signature                 | -44,              |   |                                    | 5.01                         |                                    |                          |  | - 1                         |                           |
|          | Registra  |                | JAN 0 3 2  | nns 🎤                          | And .   | H A                          | 100               |   |                                    |                              |                                    |                          |  |                             |                           |
| ЭНМ      | H 17 Rev 1/20   | 001            |  | -                              |   | 1                            | -0.00             | -   |                                    |                              |                                    |                          |  |                             |                           |

DHMH 17 Rev 1/2001

ORIGINAL

|                |   |                         | 1 = For State Registrar  | "State of Maryland / Depa<br>Cer   | artment of Health and It tificate of Death   | Mental Hygie                                    | 2000 92901  |
|----------------|---|-------------------------|--|--|--|---|---|
|                | Physic<br>/Medi   |                         | 1. Decedent's Name (First, Migdle, Last<br>David   | Bryant   |  | 2. Date of Death                                | Day H Year 3. Time of Death 27 2005 10 co f M                   |
|                | Examir  |                         | <sup>4a.</sup> Facility Name (If not institution, give<br>Harborside Hea   | -  | 4b. City, Town, or Location of Death Baltimore   |   | 4c. County of Death N/A   |
|                | Funeral<br>Director   |                         | 213-20-0010  | x 7. Age (In yrs. last birthday)  M 2 F 73 Yrs.  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Ye<br>Oct, 18, |   |
|                | Maryland -f show  | tor                     | Usual Residence of Decedent  10a. State 10b. County  Md N/A  | 10c. City, Town or Lo<br>Baltimo   |  |   | 10d. Inside City Limits 1⊠Yes 2 □ No                            |
|                | 3a or 28a   | <b>Funeral Director</b> | 10e. Street and Number<br>1200 Glenhaven   |  | 10f. Zip Code 21239  | -   | Citizen of What Country? U.S.A.                                 |
| 9036           | be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or items 23a or 28a-f show event. The Medical Examine nust be invittled at | þ                       | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced  | Armed Forces? 2/51 II  | Nas Decedent of Hispanic Origin? (SpirYss, specify Cuban, Mexican, Puerto  Yes 2€ No Specify:                | pecify Yes or No-                               | 14. Race - American Indian, Black, White, etc. Specify: Black   |
| d 21215-0036   | filed within<br>Hygiene.<br>ther than "<br>nt, Ine Mer  | e Completed             | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)<br>1.2<br>17. Father's Name (First, Middle, Last)                          | (Give life. L  | lent's Usual Occupation kind of work done during most of work O NOT use retired)  1 Worker  18. Mother's Nam | king  | . Kind of Business/Industry  parrow Point  for Sumame)          |
| Maryland       | should be and Mental a marked o   | To Be                   | David N. Bryan   |  | Georgi   | a E. Har  | ris   |
|                | s 1 and 2 should<br>f Health and Mer<br>item 27 la marke<br>other traumatic   |                         |  | kson/ sister 120   | g Address (Street and Number or Rui<br>0 Glenhaven Ro  | ad Balti:                                       | more Md.21239   |
| Baltimore,     | 000-  |                         | 20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)   | Garriso  | n Forest VA Ce   | m Ow.   | Location - City or Town, State                                  |
| Ball           | permit. Pag<br>Depertment<br>Important: I<br>any njury o  |                         | 21. Signature of Juneral Service Livens  23a. Parv. Enter the disease, or complete   | ications that caused the death. Do not ente  | 74U Reistersto   | wn Rd Ra  | rris Funeral Home   |
| Şi             | Physician<br>/Medical   |                         | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | a. Polumoni  | 4  |   | Inierval Between<br>Onset and Death                             |
| 58760,         | Examine be executed by sician and burial-transit  | ai Examiner             | Saquartially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):                 |  |   | tion how  |
| .O. Box        | taw requires that the death certificate<br>as been signed by the attending phy.<br>2 should be detached for use as the  | Physician/Medical       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |  | Ectopic pregnancy<br>Other (specify)   |   | 23d. Date of delivery<br>Month Day Year                         |
| rds, P         | w requires that<br>been signed b<br>should be deta  | þ                       | Part II. Other significant conditions con  | ntributing to death but not resulting in the un  | derlying cause given in Part I.  | 23e. Did tobacc                                 | o use contribute to the cause of death? 2 □ No 3 □ Probably 4 ▼ |
| Vital Records, | The<br>ate h<br>page  | Completed               |  |  |  | 24a. Was an autopsy performed                   |   |
| Vita           | ician:<br>certific<br>rector,   | o Be (                  | 25. Was case referred to medical examiner?   | lospital:  | 0.4  | h (Check only one)                              |   |
| o              | ding<br>h.<br>After<br>fune   | -                       | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year)  28b. Time of Injury                           | 3 DOA 4 TOTUISING NO   | me 5 ☐ Residence<br>28d. Describe how in        | 6 □Other (Specify)<br>jury occurred                             |
| Division       | o ir  | Certification;          | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - At home, farm, stre building, etc. (Specify)  |  | City or Town, Sta                               |   |
|                | ne Hospital<br>n 24 hours a<br>ne Funeral D<br>bletely filled i   | edical                  | 29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination   | sician: To the best of my knowledge, death<br>ner: On the basis of examination and/or involute<br>and manner stated. | occurred at the time, date and place,<br>estigation, in my opinion, death occur                              | red at the time, date a                         | ind place, and due to the cause(s)                              |
| )              | To the within 2 To the complete   | M                       | 29b. Signature and title of certifier  | Impereren'   | 29c. License number D 3066 /   | 29d. [  | Date signed (Month, Day, Year) 12005                            |
| _              | 4   |                         | 30. Name and address of person who co  | mpleted cause of death (Item 23a) (Type, F   | Ballimore,   | Md-2  | 1239.   |
|                | Sta<br>Registr  | _                       | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signature  | Carolles   |   |   |

|                                |  |  | 1 - For<br>State<br>Registrar   | State of Ma  | aryland      |                | rtment of H                     |                      | nd Mental H           | ygiene<br>Reg. No.           | ' U U D -                                 | 424                               | 62               |  |
|--------------------------------|--|--|---|--|--------------|----------------|---------------------------------|----------------------|-----------------------|------------------------------|---|-----------------------------------|------------------|--|
|                                | Dhyaisi  | ţ.d.   | 1. Decedent's Name (First, Middle, Last   |  |              |                |                                 |                      | 2. Date of I          | Death<br>Day                 | y Year                                    | 3. Time of                        | Death            |  |
|                                | Physici<br>/Medio  |  | Harriet Mildred Burtner   |  |              |                |                                 |                      |                       | 28                           |   | 9:15                              | $\mathbf{a}^{M}$ |  |
|                                | Examir   |  |   |  |              |                |                                 |                      |                       | 4c.                          | County of Death                           | 1                                 |                  |  |
|                                |  |  | 11500 Regnid Dr. Wheaton  |  |              |                |                                 |                      |                       | Mo                           | ntgomer                                   | У                                 |                  |  |
|                                | Funeral  |  | 5. Social Security Number 6. Se. 577-34-1618  | THE OFFICE   |              | ast birthday)  | If Under 1 Year<br>Months Days  | It Under 24<br>Hours | Min. (Month, L        | Day, Year)                   | 9. Birth<br>Cou                           | place (State o                    | r Foreign        |  |
|                                | Director   |  | Usual Residence of Decedent   | /  | 8            | Yrs.           |                                 |                      | 5/9/1                 | 927                          | Wasi                                      | nington                           | ı, DC            |  |
|                                | land<br>W  |  | 10a. State 10b. County  |  | 10c. City    | , Town or Lo   | cation                          |                      |                       |                              |   | 10d. Inside Ci                    | ity Limits       |  |
|                                | Mary   | ō  | MD Montgomer  | У  | Whea         | aton           |                                 |                      |                       |                              |   | 1 Yes                             | 2 □ No           |  |
|                                | 1 the  | Director   | 10e. Street and Number  |  |              |                | 10f. Zip Code                   |                      |                       | 10g. Citi                    | zen of What Cou                           | untry?                            |                  |  |
|                                | h with   | O E  | 11500 Regnid Dr   |  |              |                | 20902                           |                      |                       | USA                          |   |                                   |                  |  |
|                                | deat   | Funeral  | 11. Marital Status  | 12. Was Decedent I   | Ever in U.S  |                | Vas Decedent of Hi              | spanic Origin        | ? (Specify Yes or N   |                              | 14. Race - Amer                           |                                   |                  |  |
| 9                              | or Ite   | E  | 1 Never Married 2 Married   | Armed Forces?  1  Yes 2 1  | No           |                | Yes, specify Cuba               |                      | ruerto Rican, etc.)   |                              | Black, White                              |                                   |                  |  |
| 8                              | aral',   | d by   | 3 ☐ Widowed 4 Divorced  | Year or Dates:   |              |                | ☐ Yes 21X No                    | Specify:             |                       |                              | Specify: wh:                              | rte                               |                  |  |
| 2                              | within 72 hours atter death with the Maryland ene. Annual Trafural, or Items 23a or 28a-f show than "natural", or Items 23a or 28a-f show the Madical Exemples roughly to inclined at  | Completed  | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>e <i>completed)</i>  |              | (Give          | ent's Usual Occupa              | furina most of       | f working             | 16b. Ki                      | nd of Business/l                          | ndustry                           |                  |  |
| 7                              | han within   | E I  | Elementary/Secondary (0-12)   | College (1-4or 5   | +)           |                | oo NOT use retired<br>ce Manage |                      |                       | Me                           | dical                                     |                                   |                  |  |
| N<br>T                         | Hygie<br>Hygie<br>Ther I   |  | 17. Father's Name (First, Middle, Last)   |  |              |                |                                 |                      | Name (First, Middle   |                              |   |                                   |                  |  |
| ä                              | ntal h   | Be   |   |  |              |                |                                 |                      |                       |                              | Surname)                                  |                                   |                  |  |
| 2                              | d Me<br>d Me<br>mark   | 우  | Harry K. Burtner  19a. Informant's Name/Relationship (Ty                                    | na Print)  |              | 19h Mailin     |                                 |                      | Mildred :             |                              | Town State 7                              | '- C- d-1                         |                  |  |
| <u>8</u>                       | d 2 s<br>th an<br>th an<br>t7 le   |  | Terry Coates  | po, rruny  |              |                |                                 |                      | eaton, MD             |                              |   | p Code)                           |                  |  |
| ည်                             | 1 an<br>Heal<br>tem 2  |  | 20a. Method of Disposition  |  | 20b. Pla     | ace of Dispos  | sition (Name of                 |                      | Date                  | -                            | cation - City or T                        | own State                         |                  |  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Deparament of Health and Mental Hygiene. Importanent of Health and Mental Hygiene. Inportanent if the 21 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinet mast be notified at once.   |  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)                          | emoval from State  |              |                | atory or other place            | 1                    | 21 05                 |                              |   |                                   |                  |  |
|                                | artme<br>ortan<br>injur  |  | 21. Signature of Funeral Service Licens   | 90   | Unes         |                | e Cremato<br>Name and Addres    |                      |                       | -                            | sville,<br>ring, M                        |                                   | 1                |  |
| ä                              | Deparming Department of the partment  |   | Z kr   | 0135         |                |                                 |                      | cemation              |                              |   |                                   |                  |  |
|                                |  |  | 23a. Part1. Enter the disease, or compl   | cations that caused  | the death.   |                |                                 |                      |                       |                              | ces 933                                   | Approximate                       | е                |  |
|                                | Physician  | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Hemorrhage |   |  |              |                |                                 |                      |                       |                              |   | Intervat Bety<br>Onset and D      |                  |  |
| d.                             | /Medical   |  | disease or condition resulting in death)  | Due to (or as a  |              | ence of):      |                                 |                      |                       |                              |   |                                   |                  |  |
| Н                              | Examiner   |  |   | Abdomina   |              |                | neurysm                         |                      |                       |                              |   |                                   |                  |  |
|                                |  | ner  |   |  |              |                |                                 |                      |                       |                              |   |                                   |                  |  |
|                                | cuted<br>nd<br>ransi   | Examiner   | that initiated events   |  |              |                |                                 |                      |                       |                              |   |                                   |                  |  |
| Ö,                             | icate be executed<br>physicien end<br>s the burial-transit   | Ä  | resulting in death) Last  | Due to (or as a  | a consequ    | ence of):      |                                 |                      |                       |                              |   |                                   |                  |  |
| 8760,                          | ate b<br>hysic<br>the b  | dlcal  |   | l  |              |                |                                 |                      |                       |                              |   |                                   |                  |  |
| 9                              | entitio<br>ling p  | Me   | IF FEMALE:  |  |              |                |                                 |                      |                       |                              |   |                                   |                  |  |
| P.O. Box                       | eath certitic<br>attending p   | an/  | 23b. Was decedent pregnant in the past 12 months?   | 3c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy |              |                |                                 |                      |                       | 2                            | 23d. Date of delivery  Month Day Year     |                                   |                  |  |
| o.                             | the de   | Physician/Me   | 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)<br>9 ☐ Unknown 9 ☐ Unknown |  |              |                |                                 |                      |                       |                              | 10101111                                  | Day Tour                          |                  |  |
| ۵.                             | The law requires that the death certiticate be executed site has been signed by the attending physicien end page 2 should be detached tor use as the burial-transit  | 4  | Part II. Other significant conditions cor   | tributing to death bu  | ut not resul | ting in the un | deriving cause give             | n in Part I          | 23e. Did              | tobacco us                   | cco use contribute to the cause of death? |                                   |                  |  |
| Vital Records,                 | uires tha<br>signed<br>d be del  | d b  |   | 1134.5   |              |                | , <b></b>                       |                      |                       | 1⊠Yes 2□No 3□Probably 4□Unkr |   |                                   |                  |  |
| ဂ္ဂ                            | w require<br>been si   | ete  |   |  |              |                |                                 |                      |                       |                              |   |                                   |                  |  |
| Ä                              | The lav  | Completed  |   | ,  |              |                |                                 |                      |                       | s an<br>opsy<br>formed?      | 24b. Were auto<br>prior to co<br>death?   | opsy undings a<br>ompletion of ca | tuse of          |  |
|                                |  | ပိ   | 25. Was case referred to medical  |  |              |                |                                 |                      | 1 ☐ Yes               | 2 No                         | 1 🗆 Yes                                   | 2□ No                             |                  |  |
| 5                              | Physician:<br>r this certifice<br>ral director.  | ToB  | examiner?   | ospital:   | N 2 🗆        | R/Outpatient   | 3 DOA Cthe                      | _                    | Death Check only      |                              | CO. 10                                    |                                   |                  |  |
| ō .                            | eral c   |  | 27. Manner of Death   | 28a. Date of Injur<br>(Month, Day  |              | 28b. Time of   | 28c. Injury<br>Work             |                      | 28d. Describe         |                              |   | (y)                               |                  |  |
| 0                              | nding F<br>ath.<br>r: Atter<br>e funera  | ate  | 1   Natural 5 □ Pending 2 □ Accident Investigation  | (Month, Day  | r ear)       | tnjury         |                                 | ?<br>′es 2 ☐ No      |                       |                              |   |                                   |                  |  |
| Division of                    | ar death<br>rector:<br>by the  | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of Inju   | ry - At hon  | ne, tarm, stre | et, factory, office             |                      | 28f. Location         | (Street and                  | Number or Run                             | al Route Numb                     | ber,             |  |
| 5                              | tel or<br>rs afte<br>el Dir<br>ed in   | Ce   |   | building, etc  | . (Opechy)   |                |                                 |                      | Only of 10            | wii, Siale)                  |   |                                   |                  |  |
|                                | To the Hospitel within 24 hours and To the Funerel completely filled   | cal  | 29a. Certifier 1 Certifying Phys  | icien: To the best of  | f my know    | ledge, death   | occurred at the time            | e, date and p        | lace, and due to the  | cause(s)                     | and manner as s                           | tated.                            |                  |  |
|                                | the h  | Medical  | 510)  | and manner sta   | ted.         |                |                                 |                      | Accounted at the time |                              |   |                                   |                  |  |
|                                | To the Hospitel or Attending Pl<br>within 24 hours atter death.<br>To the Funerel Director: Atter th<br>completely filled in by the funeral  | 2  | 29b. Signature and title of certifier   | ROK  | )            |                | 29c. License                    | number               |                       |                              | signed (Month,                            |                                   |                  |  |
| 7                              | ()   |  | 7   |  |              |                | D29142                          | 2                    |                       | Decem                        | ber 29,                                   | 2005                              |                  |  |
|                                | 8  |  | 30. Name and address of person who co   |  |              |                |                                 | ~ 140                | 20002                 |                              |   |                                   |                  |  |
|                                | -01  |  | Charles Boyce 1030  | JI Georgia   | a Ave        | . Silv         | er Spring                       | g, MD                | 20902                 |                              |   |                                   |                  |  |
|                                | Sta<br>Registr   |  | JAN 0 3 2006  | 32. Registra   | . Jognati    | Sec.           | 1                               |                      |                       |                              |   |                                   |                  |  |

Conell

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ,          |  |                | For<br>State<br>Registrar  | State of M  | laryland  |                             | artment of F<br>rtificate of                              |   | d Mental Hyg                                | iene<br><sub>sg. No</sub> 2 0 0 5                                     | 42463  |  |
|------------|--|----------------|--|---|---|-----------------------------|---|---|---|---|--|--|
|            | Physici  |                | Decedent's Name (First, Middle, L<br>Madalone Raque  | ·   |   |                             |   |   | 2. Date of Deat                             | 27 2005°  | 3. Time of Death 01:45 pm  |  |
| )          | /Medio<br>Examir   |                | 4a. Facility Name (If not institution, g<br>11509 Stonewood  | ive street and number   | ·)  |                             | 4b. City, Town, o   |   | eath  | 4c. County of Dea   |  |  |
|            | Funeral<br>Director  |                | 5. Social Security Number  |   | ge (In yrs. Ia:<br>87   | st birthday)<br>Yrs.        | If Under 1 Year<br>Months Days                            |   | Irs. 8. Date of Birth (Month, Day, 08–13–   | Year)   | nthplace (State or Foreign<br>Country)<br>ndiana                           |  |
| Maryland   | Maryland -f ehow   | tor            | Usual Residence of Decedent           10a. State         10b. County           MD         Mont   | gomery  |   | Town or Lo                  |   |   |   |   | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No                                     |  |
|            | h with the<br>23a or 28a<br>at ke noti   | al Director    | 10e. Street and Number<br>11509 Stonewood  | Lane  |   |                             | 10f. Zip Code   | 20855   | 1   | 0g. Citizen of What C   | Country?   |  |
| 030        | d within 72 hours after death with the Maryland<br>liene.<br>r than "naturel", or Iteme 23a or 28a-f ehow<br>the Maical Erapiner must be politied at             | by Funeral     | 11. Marital Status  1X Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Deceden Armed Forces 1 ☐ Yes 2X If Yes, Give Year or Dates:   | ?<br><b>M</b> Vo  |                             | Was Decedent of F<br>f Yes, specify Cuba<br>1 ☐ Yes 250No | lispanic Origin?<br>an, Mexican, Pu<br>Specify: | (Specify Yes or No-<br>erto Rican, etc.)    | 14. Race - Am<br>Black, Wh<br>Specify: V                              |  |  |
| 9500-61212 | I within 72 ho<br>liene.<br>r than "natur<br>the Wedical   | Completed      | 15. Decedent's<br>(Specify only highest g<br>Elementary/Secondary (0-12)<br>12   | grade completed)  | ducation ade completed)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Admin Clerk |                             |   |   |   |   | s/Industry   |  |
| Marylan    | d 2 should be filed<br>th and Mental Hygis<br>7 is marked other<br>traumatic event, II   | To Be C        | 17. Father's Name (First, Middle, La<br>Bowen Carr Bowe  |   |   | Maiden Sumame)<br>t Bowell  |   |   |   |   |  |  |
|            | ss 1 and 2 shoot Heelth and Item 27 is my rother traums  |                | 19a. Informant's Name/Relationship (Type, Print)  Barbara Moskowitz/neice  19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Nu |   |   |                             |   |   |   |   |  |  |
| saltimore, | it. Pages<br>rtment of<br>rtant: If It<br>njury or o   |                | 20a. Method of Disposition  1  | cify)   | Che   | sapea                       | ke Cremat   | cory 12   | Date 2-30-2005                              | Beltsvi   |  |  |
| a<br>D     | Depa<br>Impo<br>any II   |                | > Style Dook   | mane  | 00382   |                             | Rapp Fu   | neral &   |   | ng MD 2091  |  |  |
| į          | Physician<br>/Medical<br>Examiner  | ier            | 23a. Part1. Enfer the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | y one cause on each Chro a. Due to (or a Emph   | line.   | struc                       | nonary I  |   | 331,  | Approximate<br>Interval Between<br>Onset and Death                    |  |  |
| 3/00,      | ate be executed<br>nysicien and<br>he burial-transit   | dical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | cDue to (or as  | s a conseque  | nce of):                    |   |   |   |   |  |  |
| .O. Box 6  | w requires thet the death certificate be executed<br>been signed by the attending physicien and<br>should be detached for use as the buriat-transit              | Physician/Mec  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcom 1 Live birth 4 Pregnant a   | 2 Fetal d   | eath 3                      | ]Ectopic pregnancy<br>] Other (specify) _                 | /   |   | 23d. Date of de<br>Month  | l<br>elivery<br>Day Year   |  |
| ecords, r  | law requires thet the death<br>as been signed by the atten<br>2 should be detached for u   | ρ              | Part II. Other significant conditions  | gnificant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributions. The properties of the contributions of the underlying cause given in Part I. |   |                             |   |   |   |   |  |  |
| r          | The lay  | Completed      |  |   |   |                             |   |   | 24a. Was al<br>autops<br>perform<br>1 Yes 2 | y prior to  | utopsy findings available<br>completion of cause of<br>s 2 \( \text{No} \) |  |
| Vital      | Physicien: Th<br>thi certificete<br>ral cirector, pag  | To Be          | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | Hospital:   | ient 2∏F  | R/Outpatien                 | it 3□ DOA Oth   |   | Death (Check only on                        | e)<br>ence 6 □Other (Sp   | acity)   |  |
| ion oi     | ath.<br>or: After this   |                | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat  | 28a. Date of Inj<br>(Month, D   | jury 2  | 8b. Time of<br>Injury       | 28c. Injur<br>Wor   |   |   | w injury occurred   | outy)  |  |
| DIVISION   | ital or Atternas after de ral Directo  | Certification; | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine  | building, e   | etc. (Specify)  |                             | eet, factory, office                                      |   | City or Town                                |   |  |  |
|            | To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After thir certific completely filled in by the funeral circactor. | Medical        | 29a. Certifier 12 Certifying 1 (Check only one) 2 Medical ex   | Physician: To the bes<br>aminer: On the basis<br>and manner s   | of examination  | edge, death<br>on and/or in | occurred at the tir<br>vestigation, in my o               | ppinion, death or                               | ccurred at the time, da                     | ause(s) and manner a<br>ate and place, and du<br>9d. Date signed (Mon | e to the cause(s)  |  |
|            | × × × ×  |                | 30. Name and address of person who   | . W   |   |                             |   |   |   | 12/29/0   | 5  |  |
| ı          | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)  JAN 0 3 2   | 32, Regis   | trar's Signatu  |                             |   |   |   |   |  |  |
| DH         | MH 17 Rev 1/2  | 001            | OFHIT U D Z  | UUU KARA  | A Start   | 1                           |   |   |   |   |  |  |

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| District Control |             |   |  |

|  |  |                               | 1 _ State  | laryland / Dep   |   | lealth and N   | Mental Hygie                                    | ne<br>2005                               | 42464   |  |  |  |
|--|--|-------------------------------|--|--|---|--|---|--|---|--|--|--|
| 1/4<br>1/4<br>1/4  | Physici  |                               | Registrar     Decedent's Name (First, Middle, Last)     Christopher Theodore Beve  |  | rimeate or i  | Dealli   | 2. Date of Death Month becember                 |  | 3. Time of Death  |  |  |  |
|  | /Medio<br>Examir   |                               | 4a. Facility Name (If not institution, give street and number<br>Doctors Community Hospita   |  | 4b. City, Town, or<br>Lanhar                                      | r Location of Death  |   | 4c. County of Death Prince George        |   |  |  |  |
|  | uneral<br>rector   |                               | 012-22-2136 1⊠M 2□F  | ge (In yrs. last birthday)<br>86 Yrs.  | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Ye<br>03-12-19 | 9. Bi                                    | rthplace (State or Foreign<br>ountry)<br>ermany               |  |  |  |
| Maryland   | -f ehow  | tor                           | Usual Residence of Decedent  10a. State 10b. County  MD Prince George  |  |   |  | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No          |  |   |  |  |  |
| h with the   | 3a or 28a<br>at be not   | ai Direc                      | 10e Street and Number<br>10450 Lottsford Rd.   | . Citizen of What Country?   |   |  |   |  |   |  |  |  |
| <b>UUSO</b><br>hours after deat  | Important: If itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be multiled at once. | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  12. Was Decedent Armed Forces  13. Wes 2 If Yes, Give Year or Dates:  | ?<br>No  | Was Decedent of Hill Yes, specify Cuba                            | ispanic Origin? (Sp<br>in, Mexican, Puerto<br>Specify:                           | ecify Yes or No-<br>Rican, etc.)                | 14. Race - Am<br>Black, Wh               | 14. Race - American Indian, Black, White, etc. Specify: White |  |  |  |
| d within 72 ha   | han "natur<br>e Medical  | npieted                       | 15. Decedent's Education<br>(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or   | 5+) (Give  | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired | ation<br>during most of work<br>()   |   | Kind of Business/Industry                |   |  |  |  |
| Id be filed vental Hygie   | ked other ti   | To Be Col                     | 17. Father's Name (First, Middle, Last) Rudolf Berliner  |  | e (First, Middle, Maid<br>Berliner                                | Care   |   |  |   |  |  |  |
| ind 2 shou   | 27 le mar<br>or traumat  | -                             | 19a. Informant's Name/Relationship (Type, Print) Christopher T. Bever Jr./   | al Route Number, Ci  | City or Town, State, Zip Code)<br>21057                           |  |   |  |   |  |  |  |
| Dallillore,<br>Dermit. Pages 1 &<br>Department of He   | ant: If itam<br>ury or othe  |                               | 20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  | Location - City or Town, State eltsville MD  |   |  |   |  |   |  |  |  |
| permit. Departr  | any inju   |                               | 21. Signature of Funeral Service Licensee  | 1250   | Rapp Fune   | eral & Cro   | emation Se<br>r Spring N                        | ervice<br>MD 20910                       |   |  |  |  |
| /Me<br>Exa   | sician<br>edical<br>miner  | her                           | d  |  |   |  |   |  |   |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | been signed by the attending physician and<br>should be detached for use as the burial-transit   | dical Examiner                |  |  |   |  |   |  |   |  |  |  |
| the death certif   | by the attending<br>ached for use as   | Physician/Med                 | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |  | 23d. Date of delivery  Month Day Year                             |  |   |  |   |  |  |  |
| quires that  | an signed b  | þ                             | Part II. Other significant conditions contributing to death to the Renal in Su   | on in Part I.  |   | obacco use contribute to the cause of death?  Yes 2 □ No 3 □ Probably 4 ▼Unknown |   |  |   |  |  |  |
| The law re   | is certificate has be<br>director, page 2 sho  | Completed                     | Dementiq   | 24b. Were autopsy findings available prior to completion of cause of death? No 1  Yes 2 No   |   |  |   |  |   |  |  |  |
| siciar   | s certif   | o Be                          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 Ninoatii  | ant 2 FR/Outpation   | t 3 DOA Othe  |  | (Check only one)                                | 0.500                                    |   |  |  |  |
| anding Ph  | 두 금 ㅣ  | ation: T                      | 27. Manner of Death   Matural   5   Pending   (Month, Da 2   Accident   Accident   Pending   (Month, Da 2   Accident   Accident   Pending   (Month, Da 2   Accident   Accident   Accident   Pending   (Month, Da 2   Accident   Acciden | ital: 1 Inpatient 2 ER/Outpatient 3 DOA Cher: 4 Nursing Home 5 Residence  Rea. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M 1 Yes 2 No |   |  |   |  | city)   |  |  |  |
| Itel or Att  | To the Funeral Director: After completely filled in by the funer.  | Certification:                | 4 Homicide building, et  | ury - At home, farm, stre<br>c. (Specify)  |   |  | 28f. Location (Street<br>City or Town, St       | are)                                     |   |  |  |  |
| the Hosp<br>Jin 24 hou   | the Fune   | Medicai                       | 29a. Certifier  (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st  | r examination and/or inv   | estigation, in my op  | inion, death occurr  | and due to the cause<br>ed at the time, date a  | e(s) and manner as<br>and place, and due | s stated.<br>to the cause(s)                                  |  |  |  |
| To With  | 00   | ~                             | 29b. Signature and title of certifier  R. Dakhelf, in  | · D .  | 29c. License  | 26492  |   | Date signed (Mont                        | ,   |  |  |  |
|  | 7  |                               | 30. Name and address of person who completed cause of cause of | leath (Item 23a) (Type, 1  |   | 21   |   |  |   |  |  |  |
| F  | Stat<br>Registra   |                               | 31. Date filed (Month, Day, Year)  JAN 0 3 2006  | ar's Signature   | 2012E   | ~U 3/5   | Darg  | DWIZ                                     | NIIS 30 116   |  |  |  |

|                     |  |                            | For State  | use          |                         |                        | land / De                |   | t of H                 | lealth a             |             | •                              | gieņ                    | ำกก                  | ٠٠.<br>آ                    | 42465   | -         |
|---------------------|--|----------------------------|--|--------------|-------------------------|------------------------|--------------------------|---|------------------------|----------------------|-------------|--------------------------------|-------------------------|----------------------|-----------------------------|---|-----------|
|                     |  |                            | Registrar  1. Decedent's Name (First, Mic  | Idlo I a     | et)                     |                        |                          | erinicai  | e or i                 | Jealii               |             | 2. Date of D                   | Reg. No                 |                      |                             | 3. Time of Death                              |           |
| П                   | Physicia   |                            | Stephen  | V            | urns                    |                        |                          |   |                        |                      |             | Month                          | Da                      | y )                  | 'ear                        | 5:05 A  |           |
|                     | /Medic   |                            | 4a. Facility Name (If not institu  |              |                         | mbor)                  |                          | 4b Cibe   | Town or                | r Location of        | of Death    | Dec.                           |                         | . 200<br>. County of |                             |   |           |
|                     | Examin   | er                         | Howard Cou   |              |                         |                        | Horaston                 |   | 7/ \ -                 | -619                 | Death       |                                | 40                      | How                  | 200                         | l   |           |
|                     | -  |                            | 5. Social Security Number  | 6. S         |                         |                        | yrs. last birtho         |   | 1 Year                 | If Under             | 24 Hrs.     | 8. Date of B                   | irth                    | 9                    | Birth                       | place (State or Forei                         | ian       |
|                     | Funeral<br>Director  |                            | 037-46-9653  |              | M 2□F                   | ,,,,,go (              | 45 Yrs                   | Months  | Days                   | Hours                | Min.        | Sept                           | 19 Year)                |                      | Cou                         | de Island                                     | -         |
|                     |  | 1                          | Usual Residence of Decedent  |              |                         |                        |                          |   |                        | 1                    |             | Joepe                          |                         |                      |                             |   |           |
|                     | yland  |                            | 10a. State 10b. Cou  | ity          |                         | 100                    | . City, Town o           | Location  |                        |                      |             |                                |                         |                      |                             | 10d. Inside City Limi                         | its       |
|                     | Mar<br>9-f sl  | io                         | Maryland How   | ard          |                         |                        | Ellico                   | tt Cit  | ý                      |                      |             |                                |                         |                      |                             | 1 ☐ Yes 2X☐ N                                 | No        |
|                     | h the  | ire                        | 10e. Street and Number   |              |                         |                        |                          | 10f. Zip  | Code                   |                      |             |                                | 10g. Ci                 | tizen of Wh          | at Cou                      | ntry?   |           |
|                     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>sther then "natural", or Items 23e or 28e-f show<br>ant, the Medical Evan it armat be notified at   | Funeral Director           | 3429 Manor La  | ne           |                         |                        |                          | 2   | 1042                   |                      |             |                                |                         | USA                  |                             |   |           |
|                     | dea<br>bms   | ner                        | 11. Marital Status   | -            | 12. Was Dec<br>Armed Fo | edent Ever             | in U.S.                  | 3. Was Dece                                     | dent of H              | ispanic Ori          | gin? (Sp    | ecify Yes or N<br>Rican, etc.) | 0-                      | 14. Race -<br>Black, |                             | can Indian,                                   |           |
| 9                   | or It  | F                          | 1 X Never Married 2 ☐ M  |              | 1 ∐Yes<br>If Yes, Gi    | 2 X No                 |                          | 1 ☐ Yes   |                        | Specify:             |             | , , ,                          |                         | Specify:             |                             |   |           |
| g                   | ural',   | d by                       | 3 Widowed 4 Divord   | ed           | Year or D               | ates:                  |                          |   | -41.                   |                      |             |                                |                         |                      |                             |   |           |
| Ω.                  | 72 h   | Completed                  | 15. Deced<br>(Specify only hig   |              |                         |                        | 16a. De                  | ecedent's Usu<br>live kind of wo<br>e. DO NOT u | al Occupa<br>rk done d | ation<br>during mos  | t of work   | ing                            | 16b. K                  | ind of Busi          | ness/Ir                     | dustry  |           |
| 2                   | within ne.   | μ                          | Elementary/Secondary (0-12   | )            | College (               | 1-4or 5+)              |                          | ical A  |                        |                      |             |                                | Do                      | ctors                | Ωf                          | fico  |           |
| 2                   | lled v<br>lygie<br>her t   | ပိ                         | 17. Father's Name (First, Midd   | h last       | 4                       |                        | ried                     | icai A  | SSIS                   |                      | r'e Nam     | e (First, Middl                |                         |                      |                             | rice  |           |
| anc                 | be fi  | ă                          |  |              |                         |                        |                          |   |                        |                      |             | Vardman                        | e, Maluer               | ourname)             |                             |   |           |
| ž                   | d Mer<br>nark  | 7                          | John J. Bur  |              |                         |                        | 105 1                    | - ilia - Addan                                  | /Canada                |                      |             |                                | hav City                | Tour C               | - to 7:                     | - Code)                                       |           |
| Maryland 21215-0036 | 12 st<br>h and<br>7 Is r<br>treur  |                            |  |              |                         |                        | 1                        | _   |                        |                      |             | al Route Num                   |                         |                      |                             |   |           |
|                     | 1 and<br>Healt<br>em 2<br>ther   |                            | Annie P. Burn 20a. Method of Disposition   | 5, 1         | Other                   | 20                     |                          |   |                        |                      |             | pe Val                         |                         | Cation - C           |                             |   | - 77      |
| کّ                  | ages<br>or o   |                            | 1 Burial 2 Crematio  | n 3 🗆        | Removal from            |                        | Ob. Place of D cemetery, |   |                        |                      | 10/5        | 21 /05                         |                         |                      | •                           |   |           |
| ≣                   | t. Pa<br>rtmer<br>rtent<br>njury   | 1                          | `4 □Donation 5 □Other  |              | •                       | 1                      | Metro C                  |   |                        |                      |             |                                |                         |                      |                             | Maryland                                      |           |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23e or 28e-f show eny injury or other treumatic event, I'm Medical Ever, it are result by notified at once. |                            | 21. Signature of Funeral Service Thomas Gre  |              | 1500                    | -                      |                          | Crema<br>299 F                                  | tion<br>rede           | Soci<br>rick         | ety<br>Roac | Of Mar<br>Balti                | ylane<br>more           | d Inc<br>, Mar       | yla                         | nd 21228                                      |           |
|                     |  |                            | 23a. Part1. Enter the disease shock, or heart failure. I                           | or com       | plications that         | aused the              | death. Do not            | enter the mod                                   | le of dyin             | g, such as           | cardiac     | or respiratory                 | arrest,                 |                      |                             | Approximate<br>Interval Between               |           |
| SE N                | Physician  |                            | Immediate Cause (Final disease or condition  | ,            | Cer                     | 15:0                   |                          |   |                        |                      |             |                                |                         |                      |                             | Onset and Death                               |           |
|                     | /Medical   |                            | resulting in death)  |              | a. Due to               | (or as a cor           | nsequence of):           |   |                        |                      |             |                                |                         |                      |                             | 2 0053  |           |
| Ľ                   | Examiner   |                            | Sequentially list conditions   | -            | b                       |                        |                          |   |                        |                      |             |                                |                         |                      |                             |   |           |
| (                   | D ==   | ner                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | ,            |                         | (or as a cor           | nsequence of):           |   |                        |                      |             |                                |                         |                      |                             |   |           |
| V                   | acute<br>ind<br>trans  | Examiner                   | that initiated events<br>resulting in death) Last                                  | 1            | c                       |                        |                          |   |                        |                      |             |                                |                         |                      |                             |   |           |
| 760,                | ate be executed<br>hysician and<br>the burial-transit  | ũ                          | 1630 RWIG III CEARITY EAST   |              | Due to                  | (or as a cor           | nsequence of):           |   |                        |                      |             |                                |                         |                      |                             |   |           |
| 876                 | ate b  | dicai                      |  |              | d                       |                        |                          |   |                        |                      |             |                                |                         |                      | -                           |   |           |
| × 68                | The law requires that the death certifical ate has been signed by the attending phy age 2 should be detached for use as the  | Completed by Physician/Med | IF FEMALE:   |              | 00- 15                  |                        |                          |   |                        |                      |             |                                |                         | -                    |                             |   |           |
| .O. Box             | ath cuttend  | ian/                       | 23b. Was decedent pregnant in the past 12 months?                                  |              |                         | oirth 2 🔲              | Fetal death              | 3 □Ectopic p                                    |                        |                      |             |                                | İ                       | 23d. Date<br>Month   |                             | ery<br>Day Year                               |           |
| _                   | that the death<br>led by the atter<br>detached for i   | /sic                       | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  |              | 4∐Pregi<br>9□Unkn       | nant at time<br>own    | of death                 | 5 Other (s)                                     | oecity)                |                      |             |                                |                         |                      |                             | •   |           |
| Δ.                  | hat the deby   | P.                         | Part II. Other significant cond  | itions       | ontributing to d        | eath but no            | t resulting in th        | e underlying (                                  | ause aivi              | en in Part I         | 7 11 11     | 23e. Did                       | tobacco                 | use contrib          | ute to t                    | he cause of death?                            |           |
| Ś                   | rires that<br>signed b   | φ                          |  |              |                         |                        |                          |   |                        |                      |             | 1 [                            | Yes 2                   | [ <del>]   1</del>   | □ Proi                      | oably 4 □Unknov                               | wn        |
| 0.0                 | w requir<br>been si<br>should  | etec                       | // / /   |              | 6                       | _                      |                          | <i>'</i>  | - /                    | , ,                  |             |                                |                         |                      |                             |   |           |
| Vital Record        | əlaw<br>hast<br>e2s  | npi                        | Liver Failure<br>Hyperkolemia  | H            | ypatic                  | Qu                     | ncessa                   | *logsa  | 447                    |                      |             |                                | s an<br>opsy<br>formed? | prie                 | re auto<br>or to co<br>ath? | opsy findings availab<br>impletion of cause o | ole<br>of |
| E                   | : The  | Col                        | U  |              |                         |                        |                          |   | /                      |                      |             |                                | 2 No                    |                      |                             | 2 🗆 No  |           |
| /its                | Physicien:<br>this certificaral director, p  | Be                         | 25. Was case referred to med examiner?   | cal          | Hospital:               |                        |                          |   | Oth                    |                      |             | h (Check only                  |                         |                      |                             |   |           |
| of                  | Phys<br>this<br>al dir   | 은                          | 1 Yes 2 No   |              | 28a. Date               |                        | 2 ER/Outpa               |   |                        |                      |             | ome 5 Res                      |                         |                      |                             | fy)   |           |
| n C                 | ling I<br>L.<br>After<br>funer   | lon                        | 1 ☐ Matural 5 ☐ Per  |              | (Mor                    | th, Day Yea            | ar) Zob. Tiri<br>Inju    | ry M  | 28c. Injury<br>Worl    | γαι<br>k?<br>Yes 2∐I |             | 28d. Describe                  | now inju                | ry occurred          |                             |   |           |
| isi                 | Attending or death. ector: After by the fune   | icat                       | 3 Suicide 6 □ Cou  |              | e Geo Bloom             | of Injuny              | At home, farm            |   |                        | 165 2                |             | 28f Location                   | (Stroot ar              | ad Number            | or Dur                      | al Route Number,                              |           |
| Division            | or A<br>after<br>Direc<br>in by  | Certification;             | 4 Homicide det   | mined        | build                   | ing, etc. (S           | pecify)                  | street, lactor                                  | у, опісв               |                      |             |                                | own, State              |                      | or murr                     | ar noute Number,                              |           |
| _                   | Hospitel or<br>24 hours afte<br>Funerel Dir<br>tely filled in  |                            | 29a, Certifier 1 - Certi   | vina Oh      | ysician: To the         | heet of mi             | knowledge                | eath occurred                                   | at the ti-             | ne data an           | d place     | and due to the                 |                         | and mar-             | oran                        | tated   |           |
|                     | To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:  | edicai                     | (Check only 2 Medic  | al Exar      | niner: On the b         | asis of examer stated. | mination and/o           | r investigation                                 | , in my of             | pinion, dea          | th occur    | red at the time                | , date and              | d place, an          | d due t                     | o the cause(s)                                |           |
|                     | To the within 2 To the complet   | Me                         | 29b. Signature and title of cert   | <b>T</b> yer |                         |                        |                          | 29  | c. License             | e number             |             |                                |                         |                      |                             | Day, Year)                                    |           |
|                     | ⊢s⊢ō   |                            | 1 /2   | /            |                         | 12                     | 2,0                      |   | DY                     | 612                  | 0           |                                | De                      | c                    | 30                          | 2005  |           |
|                     | ^  |                            | 30. Name and address of pers   | on who       | completed care          | se of death            | (Item 23a) (Tu           |   |                        |                      |             |                                |                         | -                    |                             |   |           |
|                     | 7  |                            | F De lean  |              |                         |                        |                          |   | 13                     | Kenza                |             | Colum                          | Siz                     | חדש                  |                             | 21044   |           |
| 1                   | Sta  | ite                        | 31. Date filed (Month, Day, Ye JAN )   | ar)          | 10724<br>006 32 1       | Registrar's S          | Signature                | Ancrode 1                                       |                        | 91                   |             |                                |                         | - 10                 | -                           |   |           |
|                     | Registr  | 3                          | JAN 0  | 3 2          | UUb A                   | A.C. S. S.             | 1850 B                   |   |                        |                      |             |                                |                         |                      |                             |   |           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sandra Lee Boisseau 31, 2005 /Medical December 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Director 214-46-1669 59 Nov 4, 1946 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or iteme 23a or 28a-f show traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Directo Maryland Howard 1 ☐ Yes 2 No Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6636 Washington Blvd. Lot 70 by Funerai 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. •m 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Businesswoman Limousine Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph G. Hickey Maybert E. Clements 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: if item 27 is eny injury or other trau James M. Boisseau, Husband 6636 Washington Blvd. Lot 70 Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 01/02/06 Baltimore, Maryland 21. Signature et Edneral Service Licenses
Thomas Gregor <sup>22, Name and Address of Facility</sup> Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MCTASTATIC Breast CA /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physicien end d be detached for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death Month 5 ☐ Other (specify) Day Year P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 1 ☐ Yes 2 ☐ No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 □ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending deeth. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after deet To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1/2/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 Dulaney Valley Road Timonium, md. 21093 DR TARIY MAHMOOD Apolle 31. Date filed (Month, Day, Year) JAN 0 3 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2005

December

SANDRA

| 1_ :   | For<br>State<br>Registrar  | State of Man  |  |   | of Health a<br>of Death                            |                          | F  | Reg. No. U U                                  | 5 !                               | +2467   |  |
|--|--|---|--|---|--|--------------------------|--|---|-----------------------------------|---|--|
| 733  | ecedent's Name <i>(First, Middle, Last,</i><br>Evan Brewer Sr  |   |  |   |  |                          | Date of Dea                                  | Day   | Year<br>005                       | 3. Time of Death 7:50 Å M   |  |
| Éxaminer <sup>4a. F</sup>  | the Figure 10 to the Character of the Character of company to the Character of Control of the Character of Ch |   |  |   |  |                          |  |   |                                   |   |  |
| Director 213   | ocial Security Number 6. Second 3-36-3998 15   | 7. Age (I<br>67   | n yrs. last birthday)<br>Yrs.                      | If Under 1 Y<br>Months D                | Year If Under<br>Days Hours                        | Min. 8                   | Date of Birtl<br>(Month, Day<br>Dec 29       | 7. Year)<br>1938                              | 9. Birthpl<br>Count<br>TN         | lace (State or Foreign<br>try)  |  |
| Varyland 10a.  | State 10b. County Md. Carroll  |   | Oc. City, Town or Lo<br>Marriotts                  |   |  |                          |  |   | 10                                | 0d. Inside City Limits 1 ☐ Yes 2 📆 No   |  |
| after death with the Maratie death with the Maratie of 100.  | Street and Number 7211 Ridge Road  |   |  | 10f. Zip Co                             |  |                          |  | 10g. Citizen of V                             | Vhat Coun                         | try?  |  |
| s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, the Maryland other traumatic event, the Marilial Examinar manufactor.  To Be Completed by Funeral Director.   |  | 12. Was Decedent Eve<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give X<br>Year or Dates: | 1  | Was Deceden If Yes, specify 1 ☐ Yes 2 🗓 | t of Hispanic Ori<br>Cuban, Mexican<br>No Specify: |                          | ly Yes or No-<br>can, etc.)                  |   | e - Americ<br>k, White, c<br>whit | etc.  |  |
| Maryland 21215-0036 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other then "natural; or ritraumatic event, the Medical Exprin To Be Completed by F  | 15. Decedent's Edu<br>(Specify only highest grad<br>ementary/Secondary (0-12)  |   | (Give  | DO NOT use I                            | done during mos<br>retired)                        |                          |  | 16b. Kind of Bu                               |                                   |   |  |
| and 21 d be filed w to determine the control of the filed w 11/2 E   | 12 transportation manager tra  17. Father's Name (First, Middle, Last)  Felix Richard Brewer transportation manager tra  18. Mother's Name (First, Middle, Maide)  Myrtle Potter   |   |  |   |  |                          |  |   | ansportation  en Sumame)          |   |  |
| Maryland Maryland 22 is marke ritraumatic.   | . Informant's Name/Relationship (T)  |   |  |   |  |                          |  | e, Md 2                                       |                                   | Code) .   |  |
| O 85 = 5   | Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)  | terrioval iloin State   | 20b. Place of Dispo<br>cemetery, crei<br>Lake View |   |  | Dat<br>-4-06             |  | 20c. Location -<br>Sykesvi                    |                                   |   |  |
| Balti<br>permit<br>Departri<br>Importe<br>eny Inju   | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Haight Funeral Home & P.O. Box 195 Sykesville, Md 21784  |   |  |   |  |                          |  |   |                                   |   |  |
| Physician Ide be executed by sician and property of the personner of the p | n. Part1. Enter the disease, or complishock, or heart failure. List only onediate Cause (Final pass or condition ulting in death)  Juentially list conditions, the light of the conditions of th | Due to (or as a condition).  Due to (or as a condition).                                    | G CAN consequence of):                             | ler the mode o                          |  | s cardiac of r           | espiratory ar                                | rest,   | (                                 | Approximate Interval Between Ponset and Death Ponset and |  |
| cords, P.O. Box 68 wrequires that the death certificate been signed by the attending physhould be detached for use as it should be detached for use as it letted by Physician/Medilete  | EMALE: . Was decedent pregnant in the past 12 months? 1  | 23c. If yes, outcome of<br>1 □ Live birth 2 [<br>4 □ Pregnant at tin<br>9 □ Unknown         | Fetal death 3                                      | ⊒Ectopic pregi<br>⊒Other (speci         |  |                          |  | 23d. Dal<br>Mo                                | te of delive                      | ry<br>Day Year  |  |
| rds, P   | II. Other significant conditions co  | _   |  | _                                       |  |                          | 23e. Did tobacco use contribute to the cause |   |                                   | e cause of death? ably 4 Unknown  |  |
| al Record  The law requir cete has been s page 2 should Completed  | CORONARY   | ARTERY  | DISE   | FASE                                    | ,  |                          | 24a. Was<br>autop<br>perfor<br>1 Yes         | itopsy prior to completion of cause of death? |                                   |   |  |
| Vision of Vita   | Was case referred to medical examiner?  1 Yes 2 No  Manner of Death  Natural 5 Pending investigation  3 Suicide 6 Could not be determined  | 28a. Date of Injury (Month, Day Y   | (ear) 28b. Time of Injury                          | M 28c                                   | Other: 4 Ni Injury at Work? 1 Yes 2                | ursing Home<br>28        | d. Describe h                                | dence 6 Oth                                   | red                               |   |  |
| Div  | a. Certifier (Check only one)  Certifying Phy Dedical Exam   | sician: To the best of einer: On the basis of ei  | xamination and/or in                               | h occurred at vestigation, in           | the time, date ar<br>my opinion, dea               | nd place, anath occurred | d due to the                                 | cause(s) and ma                               | anner as st                       | ated.<br>the cause(s)   |  |
| To the within 2 To the complete complete Med   | Signature title of certifier   | and manner state  | d.   |   | icense number                                      | 4                        |  | 29d. Date signed 12/30/                       | ,                                 |   |  |
| 17 30.   | Name and address of person who c   | CTALAINO  | th (Item 23a) (Type,                               | Print)                                  | AVE B  | ALTIN                    | ORE  | MD à  | 127                               | 59  |  |
| State Registrar  | Date filed (Month, Day, Year)  | 32; Registrar's   | s Signature  | Was I                                   |  |                          |  | ·   |                                   |   |  |

DHMH 17 Rev 1/2001

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DHMH 17 Rev 1/2001

2006

|  | 1                                      | For<br>State<br>Registrar  | State of Ma  | yland       |                              | irtment of l<br>tificate of                                |                              | and Mental H                                      | ygiene 0                                   | 5                     | 42469  |
|--|--|--|--|-------------|------------------------------|--|------------------------------|---|--|-----------------------|--|
| Physician  |  | 1. Decedent's Name (First, Middle, Las   | •  |             |                              |  |                              | 2. Date of D                                      | leath<br>Day                               | Year                  | 3. Time of Death                                   |
| Physician<br>/Medical  |  |  | EVELYN   | Α.          | BER                          | LETT   |                              | Decemb  | er 26,20                                   | 05                    | 4:50 p <sup>M</sup>                                |
| Examiner   |  | 4a. Facility Name (If not institution, give  | ·  | (1 a a a b  |                              | 4b. City, Town,  |                              | of Death  | 4c. County                                 | _                     |  |
| Funeral<br>Director  |  | 210 01 2330  |  | (In yrs. la | st birthday)<br>Yrs.         | If Under 1 Year<br>Months Days                             |                              | 24 Hrs. 8. Date of E (Month, L 05-20)             |  | 9. Birth              | more place (State or Foreign intry) ARYLAND        |
| land ow  | -                                      | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City,  | Town or Lo                   | cation   |                              |   |  |                       | 10d. Inside City Limits                            |
| with the Mary as or 28a-1 eh   |  | MD. BALTI  | MORE   |             |                              |  | ISON                         |   | 1  |                       | 1 ☐ Yes 2 XXIo                                     |
| death with the Maryland one 23a or 28a-1 show remust be redified at perset or the perset or the perset or the color.   | ומו הוו                                | 10e. Street and Number 45 THEO LAN   |  |             | 10.1                         |  | 21204                        |   |  | . S.                  | Α.   |
|  | יייי איייייייייייייייייייייייייייייייי | 11. Marital Status  1 □ Never Married 2 □ Married  XX□ Widowed 4 □ Divorced  | 12. Was Decedent Ev<br>Armed Forces?<br>1 Yes 3 XX<br>If Yes, Give<br>Year or Dates: |             | 1                            | Yes, specify Cut   | oan, Mexicai                 | igin? (Specify Yes or N<br>n, Puerto Rican, etc.) |  | k, White,             | ican Indian,<br>, etc.<br>VHITE                    |
| VCLY 215-0036 thin 72 hours af an "natural", or Medical Exam   | אוכוב                                  | 15. Decedent's Ed<br>(Specify only highest gra-  | de completed)  |             | (Give                        | ent's Usual Occu<br>kind of work done<br>OO NOT use retire | during mos                   | st of working                                     | 16b. Kind of Bu                            | siness/Ir             | ndustry  |
| 212<br>212<br>213<br>3d with<br>ser than   | 5                                      | Elementary/Secondary (0-12)<br>12 YEARS  | College (1-4or 5+  | ,           |                              | HOUSE  | WIFE                         |   | OWN  | HC                    | )ME  |
| yland yland hould be file file file file file file file file   | מ                                      |  |  | BORNE       |                              |  |                              | er's Name (First, Midd                            | BECK                                       |                       |  |
| Mai<br>and 2 st<br>auth and<br>127 is n<br>er treun  |  | 19a. Informant's Name/Relationship (7 R. PAUL BERLETT  | (SON)  |             |                              |  |                              | er or Rural Route Num , LONGWOOD                  |  |                       |  |
| ERL<br>ialtimore,<br>mit. Pages 1:<br>postment of He<br>poputant: if item<br>y injury or oth   |  | 20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify  |  | cer         | netery, crer                 | sition (Name of<br>natory or other pla<br>CEMETERY         | ice)                         | Date 12-30-2005                                   | PARKVIL                                    | •                     |  |
| Balti<br>Barti<br>Permit.<br>Departi<br>Importe<br>any injt  |  | 21. Signature of Funeral Service Licen   |  | G.RUT       |                              | Name and Addr<br>CK TOWSC                                  |                              | ERAL HOME,  | CNIC                                       | O YO<br>SON,          | RK ROAD<br>MD.21204                                |
| Physician<br>/Medical  |  | 23a. Part1. Enter the disease, or compands, or heart failure. List only disease or condition resulting in death)   | a. Sep   | ne death.   |                              | er the mode of dy  | ing, such as                 | cardiac or respiratory                            | arrest,                                    |                       | Approximate<br>Interval Between<br>Onset and Death |
| 68760, (Editional by executed gothysician and as the burial-transit and ledical Examiner   | alcai Lya                              | Sequentially list conditions, if any, leading to a mount cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Use to (or as a c. Due to (or as a d  | one aque    | Ca(                          | itis   |                              |   |  |                       | tuk  |
| vision of Vital Records, P.O. Box 6 Attending Physician: The law requires that the death certif cleath. ector: After this certificate has been signed by the ettending by the funeral director, page 2 should be detached for use as | Iyaiciai                               | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ □ □ Unknown   | 23c. If yes, outcome of<br>1 □ Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown     | Fetal       | leath 3[                     | Ectopic pregnand<br>Other (specify)                        | çy                           |   | 23d. Oate<br>Mon                           |                       | ery<br>Day Year                                    |
| rds, P<br>quires that<br>an signed b   | ed by re                               | Part II. Other significant conditions co   | ontributing to death but   | not result  | ting in the u                | nderlying cause gi   | ven in Part I                |   | tobacco use contri<br>]Yes 2□No            | bute to t             | /  |
| Division of Vital Records, I or Attending Physician: The law requires to after cleath.  Director: After this certificate has been signed in by the funeral director, page 2 should be entification: To Re Compilated by              |  | 25. Was case referred to medical   |  |             |                              |  | 26 Place                     | 24a. We aut per 1 Yes                             | opsy promed? di 2200 1                     | rior to co<br>eath?   | opsy findings available impletion of cause of      |
| of Vi<br>hysici<br>his cer<br>il direc   | 2                                      | examiner?<br>1 Tes 2 Delo  | Hospital: Inpatient  | 2 □ E       | R/Outpatien                  | t 3 DOA Ot   | hor                          | ursing Home 5 Re                                  |  | or (Speci             | (y)  |
| Division of Vita tall or Attending Physician: is after death.  al Director: After this certific act in by the funeral director.  |  | 27. Manner of Death  Shatural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day   | Year) 2     | 28b. Time of<br>Injury       | 28c. Inju<br>Wa<br>M 1                                     | ıryat<br>ork?<br>]Yes 2 □    |   | how injury occurre                         | ed                    |  |
| Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ti  |  | 3 Suicide 6 Could not be determined  | building, etc.   | (Specify)   |                              |  |                              | City or T   | (Street and Number<br>own, State)          |                       |  |
| Divi   | edical                                 | 29a. Certifier (Check only one)  Certifying Ph 2 Medical Exam  | vsician: To the best of<br>iner: On the basis of<br>and manner state                 | xaminatio   | ledge, death<br>on and/or in | occurred at the trestigation, in my                        | ime, date ar<br>opinion, dea | nd place, and due to the ath occurred at the time | e cause(s) and mar<br>e, date and place, a | nner as s<br>nd due t | stated.<br>o the cause(s)                          |
| To To To To To To To To To To To To To T   | 2                                      | 29b. Signature and title of certifier  | mp   |             |                              | 29c. Licen   | se number                    | 967   | 29d. Date signed                           | -(Month,              | Day Year)  |
| 11/  |  | 30. Name and a res 1 person who d  | completed cause of dia   | ath (Item   | 3а) (Туре,                   | Print)   | tone                         | 1 mp2   | 1204                                       |                       |  |
| State<br>Registrar   |  | 31. Date filed (Month, Day, Year)  | 32. Registrar  | 's Signatu  | ire                          | and a  |                              |   |  |                       |  |
| DHMH 17 Rev 1/200  | 1                                      | JAN U-3 2  | UUb Commen   | 1 /         | ORIGI                        | NAL  |                              |   |  | _                     |  |

Amend i tem#200 c, per Frintin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 11:57 AM 27, 2005 4c. County of Death Jimmie Lee Bates December 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) October 17, 1940 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months **X**XM 2□ F Yrs 215-34-6683 65 Mississippi Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√ No Maryland Baltimore <u>Parkville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1744 Pin Oak Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter n/a Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emerson Robert Bates Lillie Mae Norton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms Jennifer Lee Bates (Daughter) 1744 Pin Oak Road Parkville, Maryland 21234 20c. Location - City or Town, State Oak Lawn Cemetery
Parkwood Cemetery Date 20a Method of Disposition 12/31/2005 12/30/2005 Baltimore, Maryland Parkville Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc 21. Signature of Foneral Service Licensey Dundalk, Maryland 7922 Wise Ave. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final ocardia mmed disease or condition resulting in death) Due to (or as a consequence MSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2√2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 2 ER/Outpatient 300A 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injun 5 Pending

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit this certificate has been signed at director, page 2 should be det within 24 hours after death.

To the Funeral Diractor: After this certific completely filled in by the funeral director,

Examine Physician/Medical

**Physician** 

/Medical

Examiner

Directo

Funeral

Completed by

Be

2

**Funeral** 

Director

al Hygiene. I othar than "natural", or itams 23a or 28a-f ahow vant, the Madical Exeminatmust be notified at

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

and Mental I

item 27 i

permit. Pages 1 Department of H Importent: if its any injury or ot once.

**Physician** 

Examiner

/Medical

Baltimore, Maryland 21215-0036

Completed by Be မှ Certification:

Medical

3 Suicide

29a. Certifier

4 Homicide

amue

State Registrar strick

32. Fegistrar's Signatur

investigation 6 Could not be determined

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Location (Street and Number or Rural Route Number, City or Town, State)

128625 completed cause of death (It m 23a) (Type, Print)

1 ☐ Yes 2 ☐ No

3100 St. Paul Street Baltimore, Maryland

MD Joseph J

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

0

Amend item#3, penfs, 178705 in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.051 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** December 5,2005 Ralph Corley 4:20 TA M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8005 Boundary Drive Forestville Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. B November 20, 1924 9. Birthplace (State or Foreign Country) South 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours M 2□ F 577-26-3872 81 Director Carolina Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "netural", or Itame 23a or 28e-f show treumetic event, the Medical Exercitient transities at Director 1 ☐ Yes 2 ☐ No Maryland | Prince George Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 8005 Boundary Drive 20747 United States death Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status ges 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. If Item 27 is marked other then "netural", or Ital 1 Never Married 2 Married 1 ZYes 2 No If Yes, Give 1943-45 Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Twelth College (1-4or 5+) Long Fence Company Fence Builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harvey Corley Edith Stokes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosa Corley/Wife 8005 Boundary Drive, Forestville MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages December 21 1 🔯 Bur ☐Removal from State ☐ Cremat permit. Page Department o Importent: If any injury or once. Arlington, Virginia Arlington National 5 Oth 2005 ecify) 22. Name and Address of Facility Robert G. Mason Funeral Home 1661 Good Hope Rd SE, Washington DC 20020 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Months Immediate Cause (Final disease or condition resulting in death) Priysician Unresectable Pancreas CAncer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 ettending physician Physician/Medical esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death NA5 Other (specify) detached 9 Unknown 9 Unknown N/A Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 😾 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 € Residence 6 ☐ Other (Specify) ٩ 1 Tyes 2₹ No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 X Natural 5 Pending Injury efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Hospitel \*\*Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 17896 12/23/2005 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed Paul H. Sugarbaker MD 106 Irving Street N.W. Washington, D.C. 20010 31. Date filed (Month, Pay, Year) JAN 6 3 egistrar's Signature 32. State 2006 Registra

CPM 05-08786 Joe Curbean

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a, P.I. 27, pen/E 3851, 1/19/06 II

| Physician (Medical Examinor 4.5 Facility Name (**Incremental property of the state  | an   | Unpend item#23a,911.27,perME. State of Mary 1-State Registrar   |                       | artment of Heal<br><i>rtificate of Dea</i>             |  | Hygiene   | 5 42473                                 |  |  |  |  |
|--|--|---|-----------------------|--|--|---|---|--|--|--|--|
| 46. Facility Rating (find installation, pive stress and number)  47. Compared Heart Hospital  48. College of the Country  49. Sould Southly Number  49. Sould Southly Number  49. Sould Southly Number  49. Sould Southly Number  49. Sould Southly Number  49. Southly Southl | •  |   | Curbe                 | ean  | Mon  | th Day Y  |   |  |  |  |  |
| Security   Security Number     |  |   |                       |  | ation of Death                                   | 4c. County of   | Death                                   |  |  |  |  |
| Usual Residence of Decoders   100. Decoders    |  | 5. Social Security Number 6. Sex 7. Age (In   |                       | If Under 1 Year If U                                   | Inder 24 Hrs. 8. Date<br>ours Min. (Mon          | of Birth (sth, Day, Year)                             | Birthplace (State or Foreit Country)    |  |  |  |  |
| Section   Sect   | 4  | Usual Residence of Decedent   |                       | cation   |  | J 03  | 10d. Inside City Limi                   |  |  |  |  |
| 23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals and shock, or heart failure. List only get pause on each line.  Wenting it is minded to Cause (Final death of country) and property of the country of the  | rector   | 7.00  | Bal                   |  |  | 10g. Citizen of Wh                                    | 1√2 Yes 2 □ N<br>at Country?            |  |  |  |  |
| 23a-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Approximation | rai D  | 5825 Waycross Rd.   |                       | 21206  |  | USA   |   |  |  |  |  |
| 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals and shock, or heart failure. List only performed and sease on each line.   | Examinar of by Fune  | Armed Forces?  Armed Forces?  1   | ı                     | f Yes, specify Cuban, Me                               | exican, Puerto Rican, et                         | tc.) Black,   | White, etc.                             |  |  |  |  |
| 230-Part1. Enter the disease, or complications shat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals intervals and shock, or heart failure. List only periodical cause (Final designs) or condition assess or condition assess or condition assess or condition assess or conditions.   Amingitis conditions are consequence of conditions are consequence of conditions.   Due to (or as a consequence of):   | ne Medical   | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  | (Give<br>life. L      | kind of work done during<br>DO NOT use retired)        | g most of working                                |   |   |  |  |  |  |
| 230 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals intervals and shock, or heart failure. List only per cause on each line.   | ent.   |   | Lat                   |  | Mother's Name (First, A                          |   |   |  |  |  |  |
| 23a Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock, or heart failure. List only operate and shock or heart failure. List only operat   | To B   |   |                       |  |  |   |   |  |  |  |  |
| 230-Part1. Enter the disease, or complications shat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals intervals and shock, or heart failure. List only periodical cause (Final designs) or condition assess or condition assess or condition assess or condition assess or conditions.   Amingitis conditions are consequence of conditions are consequence of conditions.   Due to (or as a consequence of):   | ner trau   | Beatrice Curbean Mother   | 582                   | 25 Waycross  | Road, Balt                                       |   |   |  |  |  |  |
| 230. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, intervals intervals and shock, or heart failure. List only performed to cause (final disease) or contribution of heart failure. List only performed to cause (final disease) or contribution of heart failure. List only performed to cause (final disease) or contribution of heart failure. List only performed to cause (final disease) or contribution of heart failure. List only performed to cause (final disease) or contribution of heart failure. List only performed to cause of the cause  | ry or oth  | 1   Burial 2 □ Cremation 3 □ Removal from State   | cemetery, cren        | natory or other place)                                 | 1  |   |   |  |  |  |  |
| Immediate Cause (Final death)   Secuentially list conditions, as a consequence of):  | eny inju   |   | 22                    | . Name and Address of I                                | Facility   | Baltimore,  | Md. 21202                               |  |  |  |  |
| FFEMALE   23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   9   Unk   | he burial-transit applications and transit applications and the second and the second areas are second as a second areas areas are second areas are second areas are second areas are second areas are second areas are second areas are second areas are second areas are second areas are second areas areas are second ar | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events  C.  Meningitis  Due to (or as a consequence of):  Due to (or as a consequence of):  C. |                       |  |  |   |   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of light of ligh | for use as   | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No   | Fetal death 3         |  |  |   |   |  |  |  |  |
| 25. Was case referred to medical examiner?  26. Place of Death   Check only one    27. Mapner of Death   1   | be det   |   | ot resulting in the u | nderlying cause given in                               | Part I. 23e                                      |   | ute to the cause of death               |  |  |  |  |
| Calfullate 19 0.C.M.E. December 28, 2005   | r. page 2 sho<br>Complet   |   |                       |  | 10   | autopsy prio<br>performed? dea<br>Yes 20 No 1 [       | or to completion of cause ath?          |  |  |  |  |
| Caldella Technical December 28, 2005   | e funeral directe<br>atlon; To Be  | examiner?  XXYes 2 No  27. Mapner of Death 1 Natural 5 Pending  Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye  | 4344                  | t 3 DOA Other: 4  28c. Injury at Work?                 | Nursing Home 5 28d. Des                          | Residence 6 Other                                     |   |  |  |  |  |
| Caldella To.C.M.E. December 28, 2005   | led in by th   | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory office 28f. Location (Street and Number  |                       |  |  |   |   |  |  |  |  |
| Calfullate Technical December 28, 2005   | oletely fil  | (Check only 2 Medical Examiner: On the basis of exa   | amınation and/or in   | rectured at the time, da<br>restigation, in my opinion | ata and place, and due to, death occurred at the | to the eauso(s) and mann<br>time, date and place, and | of as stated.<br>If due to the cause(s) |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | ombo Me  | · Zahreller He  |                       | O.C.M  |  |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)   32. Registrar's Signature  |  | ZABILLAH ALI  | 111                   | ·  | , Baltimore                                      | e, Maryland   | 21201                                   |  |  |  |  |

05-8824 B.K.S KATHERINE COTTMAN

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O O

|    | 0 | 1. | 7 |  |
|----|---|----|---|--|
| 14 | 6 | 14 | - |  |

|          |   | •                | 1 - For State Registrar   | olalo ol mai  | C                   | ertificate of  |   | R                                 | eg. No.                                  | ) 42414   |
|----------|---|------------------|---|---|---------------------|--|---|-----------------------------------|--|---|
|          | Physicia  | an l             | 1. Decedent's Name (First, Middle,  | Last)   |                     | ~  |   | 2. Date of Dear<br>Month          |  | 3. Time of Death  |
|          | /Medic  |                  | KATHER  | INE   |                     | COTTI  | MAN   | DEC.                              | 29 <sup>Day</sup> 2005 <sup>Ye</sup>     | 0812 A M  |
|          | Examin  | er               | 4a. Fecility Name (If not institution,  |   |                     |  | r Location of Death                         |                                   | 4c. County of D                          | eath . 1  |
| E        |   |                  | JOHNS HOPKINS  5. Social Security Number  |   | In yrs. last birtho |  | ORE CITY  If Under 24 Hrs.                  | 8. Date of Birth                  |  | Birthplace (State or Foreign                            |
|          | Funeral<br>Director   |                  | 215-58-0694   | 1 □ M 2 ØF  | 72 Yrs              | Months Days  | Hours Min.                                  | (Month, Day                       | Year) 3.3                                | Country)  MARVLAU                                       |
| -        |   |                  | Usual Residence of Decedent   |   |                     |  |   | 001110                            | 77705                                    | /   |
|          | urylan<br>ahow  | _                | 10a. State 10b. County  | 1   | Oc. City, Town o    | r Location   |   | 1                                 |  | 10d. Inside City Limits                                 |
|          | ith the Marylar<br>or 28s-f ahow  | octo             | MARYLAND  | NIA   |                     | VA   | TIMOR                                       |                                   | ITY                                      | 1,⊠.Yes 2 □ No  |
|          | with th   | Dire             | 10e. Stifeet and Number   | 2710  | 1                   | 10f. Zip Code  | 5,0   | A = 1                             | log. Citizen of What                     | Country?  |
|          | ne 23   | Funeral Director | 11. Marital Status  | 12, Was Decedent Ev                                     | er in U.S.          | 13. Was Decedent of H  | dispanic Origin? (Sp                        | ecify Yes or No-                  | 14. Race - A                             | Merican Indian,   |
| 2        | r iter  |                  | 1 Never Married 2 Marrie  | Armed Forces?   |                     | 13. Was Decedent of H  |   | Rican, etc.)                      | Black, V                                 | /hite, etc.   |
| 2        | ral', o   | l by             | 3XWidowed 4 ☐ Divorced  | d 1 Yes 2 No<br>If Yes, Give<br>Year or Dates:          |                     | 1□Yes 2⊠No   | Specify:                                    |                                   | Specify:                                 | 3LACK   |
| ה<br>ה   | filed within 72 hours after death with the Maryland<br>Hyglene.<br>ther then "netural", or fleme 23a or 28e-f ahow<br>int, the Medical Examiner must be notified at | Completed        | 15. Decedent's<br>(Specify only highest   |   | 16a. D              | ecedent's Usual Occup<br>live kind of work done<br>fe. DO NOT use retire | pation<br>during most of work               | ang                               | 16b. Kind of Busine                      | ess/Industry  |
| 7        | within<br>sne.<br>then  | du               | Elementary/Secondary (0-12)   | College (1-4or 5+)                                      | li.                 | 1-1  |   |                                   | 01.21                                    | 11-00-  |
| 7        | Hygie<br>ther<br>ant,   | ပိ               | 17. Father's Name (First, Middle, L.  | as <i>t)</i>  |                     | 10/11=11   | 18. Mother's Nam                            |                                   | Maiden Sumame)                           | HOME  |
| ō        | id be<br>lental<br>ked c  | To Be            | ROBERT  | _   | MI                  | LES  | TUL   | IA                                | . 7                                      | ONES  |
| a Z      | S should be filed with<br>and Mental Hygiene<br>is marked other tha<br>surnatic avent, he   | -                | 19a. Informant's Name/Relationshi   | p (Type, Print)   | 19b. N              | lailing Address (Street  | and Number or Run                           | al Route Number                   |  |   |
| Ξ.       |   |                  | SANDRA BROW   | IN (DAUGH   |                     | 14 WHAI  | RTON CT.                                    | BALT                              | O, MD.                                   | 21205<br>or Town, State                                 |
| ב<br>כ   | of He   |                  | 20a. Method of Disposition<br>1288urial 2 ☐ Cremation 3   | 3 □Removal from State                                   | cemetery,           | isposition (Name of<br>crematory or other pla                            | 1 .   |                                   |  | 4   |
|          | Pa<br>ant:<br>ury   |                  | 4 □Donation 5 □Other (Spe   | ecify)  | KING                | mem PAK  | 2K 01-                                      | 14-06                             | WOODLI                                   | AWN, MD.  |
| 0        | permit. Pages 1 and<br>Depertment of Health<br>Importent: If Item 27<br>any injury or other tr<br>onca.   |                  | 21. Signature of Funeral Service Li   | censee  | Viaines             | 22. Name and Addre   |   | Round                             | JR. FUN                                  | ERAL HOME   |
|          | 20244   |                  | 23a. Part1. Enter the disease, or c   | omnlications that caused th                             | ne death. Do not    | enter the mode of dvis   |   |                                   |  | Approximate   |
|          | 5   |                  | shock, or heart failure. List o<br>Immediate Cause (Final   | nly one cause on each line.                             |                     |  | _   |                                   | ,  | Interval Between<br>Onset and Death                     |
|          | Physician /Medical  |                  | disease or condition resulting in death)  |   | consequence of)     | 10 CAMOIC  | 1135 CVC                                    | 180 DIS                           | 4/7)4                                    |   |
|          | Examiner  |                  |   |   | consequence (i)     |  |   |                                   |  |   |
| 7        | n =   | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a                                      | consequence of)     |  |   |                                   |  |   |
| J        | acuted<br>ind<br>transl   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                                     | с   |                     |  |   |                                   |  |   |
| Š        | oe exe<br>cien a<br>ourial-   |                  | resulting in death) Last  | Due to (or as a   | consequence of)     |  |   |                                   |  |   |
| 000      | rtificate be executed<br>ng physicien and<br>s es the burial-transit  | Wedical          | ***   | <b>d</b>  |                     | <del></del>  |   | ··                                |  |   |
| XO       | 5 00  |                  | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of                                 | pregnancy           |  |   |                                   | 23d. Date of                             | deliven   |
| ŏ        | death ce<br>e attendi   | ciar             | in the past 12 pronths?   | 1 ☐ Live birth 2<br>4 ☐ Pregnant at tir                 |                     | 3 ☐ Ectopic pregnance<br>5 ☐ Other (specify) _                           | у   |                                   | Month                                    | Day Year  |
| į        |   | Physician/       | 9 Unknown   | 9□ Unknown  |                     |  |   |                                   |  |   |
| 'n       | requires thet the   | ру Р             | Part II. Other significant condition  | s contributing to death but                             | not resulting in th | ne underlying cause gr   | en in Part I.                               | 23e. Did to                       | bacco use contribut                      | e to the cause of death?                                |
| ecords   | equir<br>en si<br>ould  |                  |   |   |                     |  |   | 1 🗆 Y                             | es 212/No 3                              | Probably 4 Unknown                                      |
| ပ်       | 6 6 CA  | Completed        |   |   |                     |  |   | 24a. Was a autops                 | sy prior                                 | autopsy findings available<br>to completion of cause of |
| <u> </u> | Pa es   | Cor              |   |   |                     |  |   | perform<br>1 Yes                  | med? deatl                               |   |
| VII      | Phyalclan:<br>r this certific<br>ral director,  | o Be             | 25. Was case referred to medical examiner?  | Hospital:   | . W                 | Ott  | 26. Place of Deat                           |                                   |  |   |
| 5        | Phya<br>r this<br>aral di   | <b> -</b>        | 1X Yes 2 □ No<br>27. Manney of Death  | 1 ☐ Inpatient   | 28b. Tin            | le of 28c. Injui   | 4 🗆 Nursing Ho                              |                                   | ence 6 Other (5                          | Specify)  |
| Division | Attending Indeath.  ector: After by the funer   | Certification;   | 1 ☐ Matural 5 ☐ Pending<br>2 ☐ Accident investiga   |   | Year) Inju          |  | rk?<br> Yes 2 □No                           |                                   |  |   |
| <u> </u> | Attendi   | tifica           | 3 Suicide 6 Could no<br>4 Homicide determin   |   | y - At home, farm   | , street, factory, office  |   | 28f. Location (Si<br>City or Town |  | Rural Route Number,                                     |
| בֿ       | rs efter<br>ref Dir   | Cer              |   |   | (=,,,               |  |   | 0.1, 0                            |  |   |
|          | Hospital<br>24 hours<br>Funeral<br>tely filled  | edicai           | (Check only 2 Medical E   | Physician: To the best of<br>xaminer: On the basis of e | xamination and/     | leath occurred at the tile<br>or investigation, in my o                  | me, date and place,<br>opinion, death occur | and due to the c                  | ause(s) and manne<br>late and place, and | r as stated.<br>due to the cause(s)                     |
|          | To the Hospital or Attendi<br>within 24 hours efter death.<br>To the Funeral Director: A<br>completely filled in by the fu  | Med              | 29b. Signature and title of certifier   | and manner state  | ы.                  | 29c. Licens  | se number                                   | 1 2                               | 29d. Date signed (M                      | onth. Day. Year)  |
|          | 5 1 ½ 1   |                  | DILONI -  | Ohno UG   | .08                 |  | C.M.E                                       |                                   | JAN. 2, 2                                |   |
|          | n   |                  | 30. Name and address of person w  | no completed cause of dea                               | ath (Item 23a) (To  | /pe, Print)  |   |                                   |  |   |
|          | 3   |                  | MARYSMIN A  | . 160RELL MD  | 111 PEN             | N STREET, I  | BALTIMORE                                   | , MARYLAN                         | D 21201                                  |   |
|          | Sta   |                  | 31. Date filed (Month, Day, Year)   | 32. Pagistrar   |                     | 4  |   |                                   |  |   |
|          | Regist  |                  | JAN 03  | 2006  | · K                 | Good   |   |                                   |  |   |
| 131      | IMH 17 Rev 1/2  | nn1              |   |   |                     | ,  |   |                                   |  |   |

DHMH 17 Rev 1/2001

|                     |  |                  | 1 - For<br>State<br>Registrar  | State of Ma                                     | arylan          | d / Depa<br><i>Cei</i>          | artmen<br>rtificate         | t of H<br>e <i>of L</i> | ealth a           | and M                  |   | giene<br>Reg. No. | 005  | 42475                                |
|---------------------|--|------------------|--|---|-----------------|---------------------------------|-----------------------------|-------------------------|-------------------|------------------------|---|-------------------|--|--------------------------------------|
|                     | Dhusisi  |                  | 1. Decedent's Name (First, Middle, Last)                                       |   |                 |                                 |                             |                         |                   |                        | 2. Date of De   |                   |  | 3. Time of Death                     |
|                     | Physici<br>/Medi   |                  | Mary E. Cinegran   |   |                 |                                 |                             |                         |                   |                        | Decembe   | er 31             | Year 2005  | 5:50 A.M                             |
|                     | Examir   |                  | 4a. Facility Name (If not institution, give                                    |   |                 |                                 | 4b. City,                   | Town, or                | Location of       |                        |   | 7                 | ounty of Death                                     |                                      |
|                     |  |                  | Charlestown Care (   | Center  |                 |                                 | Ca                          | atons                   | svill             | .e                     |   | Ba                | ltimore  |                                      |
|                     | Funeral  |                  | 5. Social Security Number 6. Sec   | 7. Age  | (In yrs.        | last birthday)                  | If Under<br>Months          | 1 Year<br>Days          | If Under<br>Hours | 24 Hrs.<br>Min.        | 8. Date of Bir<br>(Month, Da  | th<br>v. Year)    | 9. Birth   | place (State or Foreign intry)       |
|                     | Director   |                  | 213-10-9499  | 1 2 2   | .04             | Yrs.                            |                             | ,                       |                   |                        | 2/15/   | 1901              |  | PA                                   |
|                     | and  |                  | Usual Residence of Decedent  10a. State 10b. County                            |   | 10c. Cit        | y, Town or Lo                   | cation                      |                         |                   |                        |   |                   |  | 10d Inside Challing                  |
|                     | Aaryl<br>sho   | 5                |  |   |                 | ,,                              |                             |                         |                   |                        |   |                   |  | 10d. Inside City Limits 1 ☐ Yes 2 No |
|                     | 28a-   | ect              | MD Baltimo   | ore   |                 |                                 | Cator                       |                         | lle               |                        |   | 10 011            |  |                                      |
|                     | with a or  | Funeral Director | 911 Maiden Choice  | Tama  |                 |                                 | 10f. Zip                    |                         | 1000              |                        |   |                   | n of What Cou                                      | intry?                               |
|                     | eath   | era              |  | 12. Was Decedent B                              | ivor in II      | C 12.1                          | Non Donald                  |                         | 1228              | -:-0 /0                |   |                   | 3.A.   |                                      |
|                     | lter d   | ä                | 1 Never Married 2 Married  | Armed Forces?                                   |                 | .3.                             | f Yes, spec                 | ent of His              | n, Mexicar        | gin? (Spe<br>i, Puerto | ecify Yes or No<br>Rican, etc.)   | - 14              | . Race - Ameri<br>Black, White                     |                                      |
| 936                 | or's a'  |                  | 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☑ N<br>If Yes, Give<br>Year or Dates: |                 | '                               | ∏Yes 2                      | No                      | Specify:          |                        |   | s                 | pecify:  | hite                                 |
| Ŏ                   | tiled within 72 hours atter death with the Maryland<br>Hygiene.<br>ther than "naturel", or tlems 23e or 28e-f show<br>ont, the Medical Examinational by multing at | Completed by     | 15. Decedent's Edu   | cation  |                 | 16a. Deced                      |                             |                         |                   |                        |   | 16b. Kind         | of Business/Ir                                     |                                      |
| 215                 | Pin 7  | pie              | (Specify only highest grade  | College (1-4or 5                                | 4)              | (Give<br>life. L                | kind of wor<br>OO NOT us    | k done d<br>e retired)  | <i>uring</i> mosi | t of worki             | ng  |                   |  | -5450.7                              |
| 2                   | tiled with<br>Hygiene.<br>other than   | NO.              | 10   | 505   | ,               | F                               | Iomema                      | aker                    |                   |                        |   |                   | Own Ho   | me                                   |
| nd                  | 0 - 0 0  | Be (             | 17. Father's Name (First, Middle, Last)  |   |                 |                                 |                             |                         | 18. Mothe         | r's Name               | (First, Middle,   | Maiden Si         | ımame)   |                                      |
| Maryland 21215-0036 |  | 10               | Augustus Eckenrode   | 2   |                 |                                 |                             |                         | Agne              | s Kl                   | unk   |                   |  |                                      |
| ar                  | and les me   |                  | 19a. Informant's Name/Relationship (Ty)  |   |                 |                                 |                             |                         |                   |                        | l Route Numbe   |                   |  | Code)                                |
| 2                   | コモトニ   |                  | Rosanna Lupinek -  | Niece   | -               |                                 |                             |                         | . Ca              | tons                   | ville,  | MD 21             | .228   |                                      |
| Baltimore,          | 0 0  |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑R                       | emoval from State                               | 20b. P          | face of Dispo:<br>emetery, cren | sition (Nam<br>natory or ot | e of<br>her place       |                   |                        | ate   | 20c. Loca         | tion - City or T                                   | own, State                           |
| Ë                   | permit. Pag<br>Department<br>Importent: I<br>eny Injury o  |                  | `4 □Donation 5 □Other (Specify)  |   | Alt             | a Mesa                          |                             |                         |                   | 1/5/2                  |   |                   | Alto,  |                                      |
| Sall                | Depart<br>Import<br>eny In   |                  | 21. Signature of Funeral Service License                                       |   | 6               |                                 |                             |                         |                   |                        |   |                   |  | f Catons-                            |
| _                   | <u> </u>   |                  | Weman /  | believe   | as te           |                                 |                             |                         |                   |                        |   |                   | Caton  | sville, MD                           |
|                     |  |                  | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or | cations that caused<br>le cause on each lin     | the death<br>e. | n. Do not ente                  | er the mode                 | of dying                | , such as         | cardiac o              | r respiratory ar  | rrest,            |  | Approximate<br>Interval Between      |
|                     | Physician  |                  | Immediate Cause (Final disease or condition                                    | Due to (or as a                                 | 1.00            | dial                            | 1h                          | la                      | ro fo             | ion                    |   |                   |  | Onset and Death                      |
|                     | /Medical<br>Examiner   |                  | resulting in death)  | Due to (or as a                                 | consequ         | uence of):                      |                             | 1                       |                   |                        |   |                   |  |                                      |
|                     |  | _                | Sequentially list conditions, if any, leading to immediate                     |   |                 |                                 |                             |                         |                   |                        |   |                   |  |                                      |
| ,                   | ed sit   | Examiner         | d any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a                                 | consequ         | uence of):                      |                             |                         |                   |                        |   |                   |  |                                      |
| _                   | and and II-trar  | хап              | that initiated events resulting in death) Last                                 | Due to (or as a                                 | CORSAGI         | ience of):                      |                             |                         |                   |                        |   |                   |  |                                      |
| 8760,               | death certificate be executed e attending physician and id for use as the burial-transit   |                  |  |   | · comocqu       | 201100 017.                     |                             |                         |                   |                        |   |                   |  |                                      |
| 687                 | icate<br>phys<br>s the   | dicai            |  |   |                 |                                 |                             |                         |                   |                        |   |                   |  |                                      |
|                     | death certitics<br>attending ph<br>d for use as t  | Physician/Me     | IF FEMALE:   | 3c. If yes, outcome of                          | of pregna       | ncv                             |                             |                         |                   |                        |   | -                 |  |                                      |
| Вох                 | atter<br>atter   | ciar             | in the past 12 months?   | 1 ☐ Live birth 2<br>4 ☐ Pregnant at t           | Fetal           | death 3 -                       | Ectopic pre<br>Other (spe   |                         |                   |                        |   | 230               | <ol> <li>Date of deliver</li> <li>Month</li> </ol> | ery<br>Day Year                      |
| 0                   | at the de<br>by the<br>tached  | ıysi             | 1 Yes 2 100  | 9□ Unknown                                      |                 | , a                             | 011101 (3)00                |                         |                   |                        |   |                   |  |                                      |
| Φ.                  | de de  | by Pł            | Part II. Other significant conditions con                                      | tributing to death bu                           | t not resu      | ılting in the un                | derlying ca                 | use giver               | n in Part I.      |                        | 23e. Did to   | bacco use         | contribute to the                                  | ne cause of death?                   |
| Records,            | quires<br>n sign<br>uld be   |                  |  |   |                 |                                 |                             |                         |                   |                        | 1 🗆 Y   | ′es 2□N           | lo 3 ☐ Prob  | pably 4. Dunknown                    |
| 00                  | ≥ 0 5  | lete             |  |   |                 |                                 |                             |                         |                   |                        | 24a. Was  | 20 2              | Ah Ware auto                                       | psy findings available               |
| Re                  | 0 4 0  | Completed        |  |   |                 |                                 |                             |                         |                   |                        | autop   |                   | prior to co  | mpletion of cause of                 |
|                     |  | a                | 25. Was case referred to medical   |   |                 |                                 | <del></del> :               |                         | 00 01             | -4 D4b                 |   | 22110             | 1 🗆 Yes  | 2□ No                                |
|                     |  | 0 0              | examiner?  | ospital:<br>1                                   | t 2 🗆 1         | ER/Outpatient                   | 3□ DOA                      | Other                   |                   |                        | (Check only on the Solid Residual Check on the Solid Resi |                   | 1011   |                                      |
| 0                   | g Phys<br>er this<br>eral di   | n: T             | 27. Manner of Death  | 28a. Date of Injury<br>(Month, Day              | ,               | 28b. Time of                    |                             | ic. Injury              |                   |                        | 8d. Describe h  |                   |  | 7)                                   |
| 0                   | Attending it death. Sector: After by the fune  | atio             | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation                           | (Worth, Day                                     | rear)           | Injury                          | М                           |                         | es 2□N            | lo                     |   |                   |  |                                      |
| Division of         | Atte<br>er de<br>recto<br>by th  | tific            | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of Injurbuilding, etc.               | y - At ho       | me, farm, stre                  | et, factory,                | office                  |                   | 2                      | 8f. Location (S   | treet and N       | lumber or Rura                                     | I Route Number,                      |
| Ö                   | rs aft<br>rs aft<br>el Dia   | Certification:   |  | Dulluling, etc.                                 | (Opocny         | /                               |                             |                         |                   |                        | City or Tow   | m, State)         |  |                                      |
|                     | nospi<br>uner<br>uner  |                  | 29a. Certifier 1 Certifying Phys   | icien: To the best of                           | my knov         | vledge, death                   | occurred a                  | t the time              | , date and        | place, a               | nd due to the o   | ause(s) an        | d manner as st                                     | ated.                                |
|                     | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer  | ledical          |  | and manner state                                | ed.             | on and/or Inv                   | estigation, i               | п ту орг                | mon, deat         | - occurre              | u at the time, c  | ate and pla       | ace, and due to                                    | the cause(s)                         |
|                     | To To Con  | Σ                | 29b. Signature and title of certifier  |   |                 |                                 | 29c.                        | License                 | number            |                        |   |                   | igned (Month,                                      | Day, Year)                           |
|                     | 2  |                  | leroer Bo  | whi   | in              | 1                               | DY                          | 43                      | 77                |                        | ĺ   | 12/3              | 1/05   |                                      |
|                     | '}   |                  | 30. Name and address of person who cor   | npleted cause of de                             | ith (Item       | 23a) (Type, F                   | Print)                      |                         |                   |                        | _   |                   |  |                                      |
|                     | v  |                  | Densen Bowlin  | mb 711  | Ma              | iden (                          | Choi                        | ce                      | Lax               | ie,                    | Caton.  | sv11/             | e, mi  | ) 21228                              |
|                     | Sta  | _                | JAN 0 3 2006   | 32. Registra                                    | 's Signat       | and it                          |                             |                         |                   | ,                      |   |                   | ,  |                                      |
|                     | Registr  | ar               | 07.11 0 0 2000   | THE PARTY AND                                   | 1               |                                 |                             |                         |                   |                        |   |                   |  |                                      |

|                            |   | -                | 1- For State Registrar  State of Maryland / Department of Hea  Certificate of De   |   | 2005 4267   | 6          |
|----------------------------|---|------------------|--|---|---|------------|
|                            | Physici   | an               | Decedent's Name (First, Middle, Last)  | 2. Date of Death<br>Month                                       | Day Year 3. Time of Dear                          |            |
|                            | /Media  | al               | Fannic Cobb  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Loc  | pation of Death   | - 22 2005 8 - /<br>4c. County of Death            | 3.01       |
| 4                          | Examir  | er               | Maryland Ceneral Hospital Buttimo  |   | NA  |            |
| -                          | Funeral   |                  | 5 Social Security Number 6 Sex 7, Age (In vrs. last birthday) If Under 1 Year If   | Under 24 Hrs. 8. Date of Birth<br>Jours Min. Month, Day, Ye     | 9. Birthplace (State or For Country)              | eign       |
| ш                          | Director  |                  | 225-40-4232 TM 4 73 Yrs.   | Feb 14,19   | 932 Virginia                                      |            |
|                            | and   |                  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   | 10d. Inside City Lir                              | nits       |
|                            | Many<br>I sh  | ţ                | MD N/A Baltimore City  |   | 1 Yes 2   | No         |
|                            | filed within 72 hours after death with the Maryland<br>Hygiene.<br>tither than "netural", or Items 23e or 28e-f show<br>with the Medical Examiner roust be muffled at   | Director         | 10e. Street and Number 10f. Zip Code   | 10g.  | Citizen of What Country?                          |            |
|                            | ath wil   | rai              | 2128 Park ave 21217  |   |   |            |
|                            | after dea<br>or Items   | Funeral          | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces:  13. Was Decedent of Hispar If Yes, specify Cuban, N   | nic Origin? (Specify Yes or No-<br>lexican, Puerto Rican, etc.) | 14. Race - American Indian,<br>Black, White, etc. |            |
| 336                        | urs aft   | þ                | 3 Widowed 4 □ Divorced Year or Dates:  | pecify:   | Specify: Black                                    |            |
| 21215-0036                 | 72 hours<br>"netural",  | Completed        | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done durin  | 1 16i   | b. Kind of Business/Industry                      |            |
| 21                         | ithin 7   | nple             | (Specify only highest grade completed)  (Give kind of work done durin life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)   |   | R. C. A. Jan                                      |            |
| 121                        | iled w<br>Hygier<br>Iher tl   | ဒီ               | 12 House Keep  17. Father's Name (First, Middle, Last)  18.  | . Mother's Name (First, Middle, Mai                             | Bey Scouts  |            |
| and                        | ould be filed with<br>Mental Hygiene.<br>arked other than<br>atic event, It e M   | To Be            |  |   |   |            |
| Maryland                   | s 1 and 2 should be filed within 72 hr<br>If Health and Mental Hygiene<br>Item 27 is marked other than "netu<br>other traumatic event, It e Medical   | F                | 19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and</i>  | Vinginia Bo   | ity or Town, State, Zip Code)                     |            |
|                            | and 2<br>alth a<br>27 Is  |                  |  | . Baltimore N   | laryland 21217                                    |            |
| Baltimore,                 | iges 1 and 2<br>at of Health<br>if item 27<br>or other tra  |                  | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   |   | c. Location - City or Town, State                 |            |
| Ë                          | Pages<br>Iment of I<br>tant: If it<br>jury or o   | ١.,              | '4' □Donation 5 □ Other (Specify) South Son Fore St V  |   |   |            |
| Ball                       | permit. Pages 1 and 3<br>Department of Health<br>Important: If item 27<br>any injury or other tr<br>once.   |                  | 21. Signature of Funeral Service Licensee  Renald a   Renald a   108. Wa   | shayson Funer   | alstime md 2120,                                  | /          |
|                            |   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, st shock, or heart failure. List only one cause on each line.   | 0 1   | Onset and Death                                   |            |
|                            | Physician   |                  | Immediate Cause (Final disease or condition resulting in death)  a. ASCVD-Arterius derotic   | Cardiovaseular.   | Disease   |            |
| 1                          | /Medical<br>Examiner  |                  | Due to (or as a consequence of):  Sequentially list conditions  b. DIABETES MELLITUS   |   |   |            |
|                            |   | ie.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):   |   |   |            |
|                            | cuted<br>nd<br>ransit   | Examiner         | Cause (Disease or injury that initiated events  C. HYPERTENSION  |   |   |            |
| 760,                       | ate be executed<br>hysician and<br>the burial-transit   |                  |  |   |   |            |
|                            | cate b  | dicai            | d  |   |   |            |
| Box 68                     | eath certifica<br>attending ph<br>for use as th   | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy   |   | 23d. Date of delivery  Month Day Year             |            |
| P.O. E                     | that the death cer<br>ed by the attendir<br>detached for use  | hysici           | 1 ☐ Yes 2 MNo 4 ☐ Pregnant at time of death 5 ☐ Other (specify)<br>9 ☐ Unknown 9 ☐ Unknown   |   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,           |            |
|                            | es tha<br>igned i   | by P             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in   |   | cco use contribute to the cause of death          |            |
| ord                        | w requires<br>been signi<br>should be   |                  |  | 1 ☐ Yes   | 2 No 3 Probably 4 Unkn                            | nwc        |
| Division of Vital Records, | Attending Physician: The law requires that the death certifica r death. r death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it | Completed        |  | 24a. Was an<br>autopsy<br>performe<br>1 ☐ Yes 2 🛣               |   | able<br>of |
| ita                        | ian:<br>ortifica<br>ctor, F   | BeC              | 25. Was case referred to medical   | B. Place of Death (Check only one)                              |   |            |
| × <                        | hyaid<br>this ce  | ဂ္               | 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other:  | 4 Nursing Home 5 Residence                                      |   |            |
| o uc                       | ling P  | lon:             | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1 Natural 5 □ Pending (Month, Day Year) Injury M 1 □ Yes   | 28d. Describe how 2 □ No  | injury occurred                                   |            |
| isic                       | uttendia<br>death.<br>ctor: A<br>y the fu   | ficat            | 2 Accident investigation 3 Suicide 6 Could not be determined determined determined.  | 28f. Location (Stree  | et and Number or Rural Route Number,              | -          |
| Ω̈́                        | after after Directory   | Certification;   | 4 Homicide determined building, etc. (Specify)   | City or Town, S   | itate)  |            |
|                            | To the Hospital or Attending Phyaician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.                             | edical C         | 29a. Certifier  1  Certifying Physician: To the best of my knowledge, death occurred at the time, of the control of the contro | on, death occurred at the time, date                            | and place, and due to the cause(s)                |            |
|                            | To th<br>within<br>To th<br>compl   | Me               | 29b. Signature and title of certifier 29c. License nu  | ımber 29d   | . Date signed (Month, Day, Year)                  |            |
|                            |   |                  | Hough Surenneh , MD D445   | res De  | cember. 22, 200                                   | 5          |
|                            |   |                  | 30. Nam and address of person who completed cause of death (ftem 23a) (Type, Print)  | No til R.   | Himan AA  |            |
| 100                        |   |                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | Trospiton. 1 see  | TOWIC. TOO  |            |
|                            | St<br>Regist  | ate<br>rar       |  |   |   |            |
|                            |   |                  |  |   |   | -          |

|                     |  |                  | State of Maryland / Dep  | artment of Health and Monthsicate of Death  | ental Hygi                          | ene   | 1.21.77                             |  |
|---------------------|--|------------------|--|---|-------------------------------------|---|-------------------------------------|--|
|                     |  |                  | 1 - State Registrar  1. Decedent's Name (First, Middle, Last)  |   | 2. Date of Death                    | g. Noi- O O O                               | 3. Time of Death                    |  |
|                     | Physici  | an               | William J. Carey   |   | Month                               | Day Year                                    | 7:08A M                             |  |
|                     | /Medic   |                  | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  | Dec 28,2                            | 4c. County of Deat                          | h                                   |  |
|                     | Examin   | er               | Southern Maryland Hospital   | Clinton   |                                     | Prince G                                    |                                     |  |
|                     | Funeral  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.                                | 8. Date of Birth<br>(Month, Day,    | th 9. Birthplace (State or Foreign New York |                                     |  |
|                     | Director   |                  | 132 03 0265 XX 2 F 85 Yrs.   | Months Days Hours Min.  | Sept 8,                             | 1920 New                                    | York                                |  |
|                     | pu »   |                  | Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or L   | ocation   | bept 0,                             | 1720  | 10d. Inside City Limits             |  |
|                     | ethor  | 5                | Maryland Prince George's Clinton   |   |                                     |   | 1 □ Yes 2 □ No                      |  |
|                     | 28a-f  | ect              | 10e. Street and Number   | 10f. Zip Code   | 10                                  | g. Citizen of What Co                       |                                     |  |
|                     | with or  | ā                | 7903 Anne Court  | 20735   |                                     |   | ŕ                                   |  |
|                     | within 72 hours aftar death with the Maryland<br>ene.<br>then "natural", or items 23e or 28e-f ehow<br>the Medical Examinat the motified at  | Funeral Director |  | Was Decedent of Hispanic Origin? (Spei<br>If Yes, specify Cuban, Mexican, Puerto F      | cify Yes or No-                     | United S<br>14. Race - Ame                  | rican Indian,                       |  |
| 9                   | or ite   | Ē                | 1 Never Married 2 Married Armed Forces?  1 Never Married 2 Married   Armed Forces?  X X Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y  |   | Rican, etc.)                        | Black, White                                | e, etc.                             |  |
| 8                   | ral',  | d by             | 3 Widowed 4 Divorced Year or Dates:  | 1 ☐ Yes XX No Specify:  |                                     | Specify:                                    | White                               |  |
| 5-0                 | 72 h<br>"natu  | Completed        | (Specify only highest grade completed) (Give   | edent's Usual Occupation  e kind of work done during most of working  DONOT be revised. | ng 1                                | 6b. Kind of Business/                       | Industry                            |  |
| 12                  | within the n   | g.               | Elementary/Secondary (0-12) College (1-4or 5+)   | DO NOT use retired)   |                                     | Dated                                       |                                     |  |
| d 2                 | Hygie<br>Hygie<br>other  | ပိ               | 12 4 USAF  | 18. Mother's Name   | (First, Middle, M                   | Retired<br>Maiden Sumame)                   |                                     |  |
| an                  | d be<br>ental<br>ked o   | To Be            | Charles Carey  | Mary Ka   | ne                                  |   |                                     |  |
| Maryland 21215-0036 | shoul<br>nd M  | -                | 19a. Informant's Name/Relationship (Type, Print) 19b. Mail   | ing Address (Street and Number or Rural   | Route Number,                       | City or Town, State, 2                      | Zip Code)                           |  |
| Ž                   | s 1 and 2 should be filed within 72 hours aftar death with the Marylan of Heelth and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other treumatic event, the Medical Examinar must be notified at  |                  | Margaret T. Carey (Wife) 70  | 903 Anne Court, Cli   | nton MI                             | 20735                                       |                                     |  |
| Je,                 | of He<br>of He<br>item   |                  | 20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cametery, cre   | position (Name of paratory or other place) Jan 3, 2                                     | ate 2                               | 0c. Location - City or                      | Town, Slate                         |  |
| Ĕ                   | Page<br>nent<br>ent: ii<br>ury o   |                  | 4 □Donation 5 □Other (Specify)   Resurred  | ction Comptony  |                                     | Clinton, Ma                                 | aryland                             |  |
| Baltimore,          | permit. Pages Department of the important: if ite eny injury or of once.   |                  | 21. Signalure of Funeral Service Usen see  | 22. Name and Address of Facility Lee  | Funeral                             | Home, Inc                                   | 5633 Old                            |  |
|                     | AU = G G   |                  | 111111111111111111111111111111111111111  | Alexandria Ferry R  | d Clint                             | on MD 20                                    | 0735<br>Approximate                 |  |
|                     |  |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  | ED! S DI  | S C A                               | 5 ~   | Interval Between<br>Onset and Death |  |
| H                   | Pnysician<br>/Medical  |                  | Due to (or as a consequence of):   | ER'S DIS  |                                     |   |                                     |  |
|                     | Examiner   |                  | CHRONIE DA   | BSTRUCTIVE LO   | ING D                               | ISEASE                                      |                                     |  |
|                     |  | Jer              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |   |                                     | - 00  |                                     |  |
|                     | cuted<br>nd<br>ransit  | Examiner         | that initiated events  | EROTIC HEART  | - 0/56                              | AJC   |                                     |  |
| 760,                | ite be executed<br>ysicien and<br>ne burial-transit  |                  | Due to (of as a consequence of).   | EDIO MYO PATH   |                                     |   |                                     |  |
| 6876                | w = 0  | dicai            | d. Vichtinger en   | CDIO EN FOTO (1)  | /                                   | -   |                                     |  |
| 9 ×                 | ding I   | Me               | IF FEMALE: 23c. If yes, outcome of pregnancy   |   |                                     | 23d. Dale of del                            | iven                                |  |
| Box                 | leath<br>atter   | clar             | in the past 12 months?   | ☐Ectopic pregnancy ☐ Other (specify)  |                                     | Month                                       | Day Year                            |  |
| P.O.                | the d  | hysiclan/Med     | 9 Unknown  |   |                                     |   |                                     |  |
| <u>ر</u>            | s that<br>med t  | by P             | Part II. Other significant conditions contributing to death but not resulting in the   |   | 23e. Did tob                        | acco use contribute to                      | the cause of death?                 |  |
| Vital Records,      | en sig   | pe               | CHRONIC RENAC PAILUR   |   | 1 🗀 Yes                             | s 2 No 3 Pr                                 | obably 4 (TUnknown                  |  |
| ၁၁                  | lawr<br>es be<br>2 sh  | Completed        | BREAKIC BRAIN SYND   | R DISEASE   | 24a. Was an autopsy                 | prior to                                    | topsy findings available            |  |
| Œ.                  | The<br>cate h  | 5                | ORGANIC BRAIN SYND   | KOME  | perform<br>1 Yes 2                  | death?<br>INo 1 ☐ Yes                       | 2□ No                               |  |
| Vita                | icien:<br>sertific<br>ector,   | Be               | 25. Was case referred to medical examiner?  Hospital: Hospital:  | 26. Place of Death  |                                     |   |                                     |  |
| of                  | Phys<br>this<br>ral dir  | T.               | 1 Yes 2 No Postian 1 Inpatient 2 R/Outpatie  27. Manner of Death 28a. Date of Injury 28b. Time   |   |                                     | nce 6 Other (Spec<br>winjury occurred       | cify)                               |  |
| 0                   | ding<br>th.<br>After   | tion             | 1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation  | Work?<br>M 1 ☐ Yes 2 ☐ No   |                                     | ,,  |                                     |  |
| Division            | Atter<br>r dea<br>ector<br>by the  | ifica            | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s  | treet, factory, office 2  | 8f. Location (Str.<br>City or Town, | eet and Number or Ru                        | ural Route Number,                  |  |
| ă                   | s afte<br>el Dir   | Certification:   | 4 Homicide Solonimod building, etc. (Specify)  |   | City of Town,                       | State)                                      |                                     |  |
|                     | To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death.  To the Funerel Director: After this certificate hes been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the |                  | 29a. Certifier (Check only (Ch |   |                                     |   |                                     |  |
|                     | the the the the the the the the the the  | Medical          | one) and manner stated.  | 29c. License number   | 29                                  | d. Date signed (Mont.                       | h. Dav Year)                        |  |
|                     | F. ₹ 5 8   |                  | 29b. Signature and title of certifier funds for the signature and title of certifier funds for the signature and address of person who completed cause of death (Item 23a) (Type 13.7.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1  | N 15789   | TUND                                | FLEMLOR                                     | 29 2005                             |  |
|                     | IXO  |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type   | Print) DANILA IF  | FM                                  | D   | 5.7,555                             |  |
|                     | 10.  |                  | 17/60 CED DKING ON PACKAGE.  | CLINTON MAP   | YIND                                | P 20  | 735                                 |  |
|                     | Sta  | ate              | 31. Date filed (Month, Day, Year) 32. Registrar's Signature /  | ,   |                                     |   |                                     |  |
|                     | Regist   | rar              | JAN 0 3 2006   | Carles  |                                     |   |                                     |  |
| DH                  | IMH 17 Rev 1/2   | 2001             | ODIO   | GINAL   |                                     |   |                                     |  |
|                     |  |                  | Onic   | ALL VAL   |                                     |   |                                     |  |

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Year 0505A.M. ARTIN December 30 2000 /Medical 4c. County of Dealh 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Burnie ARUNdel BAHimore Washinston medical center GKN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 131-18-9645 Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Min. Voar 1**⊠**M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23a or 1.5.A MOOD 12. Was Decedent Ever in U.S. Armer Forces? 1 Yes 2 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1947-70 Jhite þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other then. Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ADYS EDNA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON CT. SEVERN MID. 21144 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Department o Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral en ice Dicenses 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each fine Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fmmediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmorrey /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate has all director, page 2 2∏ No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, streel, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D027415 12/30/2005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAltimore Washinton Medical Center, Filen Burnic 31. Date filed (Month, Day, Year) State JAN 03 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygietie 15 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DECEMBER 29 Elizabeth Anne Christopher 2005 3:10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Min. A(Month, Pay Year) 1927 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Maryland . Social Security Number 216-24-1293 **Funeral** 1 M 2 XF Director Usual Residence of Decedent 10d. fnside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No Director Baltimore Baltimore 10g. Citizen of Whaf Country? 10e. Street and Number 10f. Zip Code 21286 USA 610 Coventry Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic avent once. 17. Father's Name (First, Middle, Last) Anna Marie Albrecht Adam Walter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 610 Coventry Rd. Baltimore, Md. 21286 Mr. John M. Christopher, Jr./ Hus. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Hilltop Service Co. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1-2-06 Towson, Md. 4 □Donation 5 □ Other (Specify) <sup>22. Name of the control of the cont</sup> 21. Signature of Fundal Service License e Approximate Interval Between Onset and Death 23a. Part1. Enter the disea of or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician DOXIO /Medical Due to (on a a consequence of): Examiner neumon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inifiated events resulting in death) Last Due to for as a consequence of Examiner physician and s the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medicai IF FEMALE: for use 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 99 1 Yes 2 No 3 Probably 4 Noknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 2 🗆 No 2. No 1 ☐ Yes 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Infury 27. Manner of Death 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai (Check only one) and manner stated 29b. Signature and title of certifie North Pavillian Suite 550 ted cause of death (Item 23a) (Type, Print) 31. Date fied (Month, Day, distrar's Signature

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

CPM05-08779 Stella Clayton

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                | Olayed   | )11            | 1 - For<br>State<br>Registrar   | State of Ma  | aryland            |                      | artment o   |                            | h               | F                                     | Reg. No.      | 105  | 42480                                       |
|----------------|--|----------------|---|--|--------------------|----------------------|---|----------------------------|-----------------|---------------------------------------|---------------|--|---|
|                | Physici  | an             | 1. Decedent's Name (First, Middle, La:<br>STELLA CLA  | ŕ  |                    |                      |   |                            |                 | . Date of Dea<br>Month                | Day           | Year   | 3. Time of Death                            |
| ,              | /Medic   |                | 4a. Facility Name (If not institution, giv  |  |                    |                      | 4b. City, Tow                                       | m, or Location             |                 | ecembe                                | -             | 2005<br>unty of Death                        | 10:00 A <sup>M</sup>                        |
|                | Lamin  | e.             | 2730 Ashland Avenu  |  |                    |                      | В   | altimo                     | re              |                                       |               | N/A  |   |
|                | Funeral<br>Director  |                | 5. Social Security Number 6. S 215 52 0949  | ex 7. Age  | in yrs. lasi<br>56 | t birthday)<br>Yrs.  | If Under 1 Y<br>Months Da                           | ear If Unde<br>ays Hours   | Min.            | Date of Birti<br>(Month, Day<br>ay 16 | , 1949        | 9. Birthp<br>Cour<br>MAR                     | place (State or Foreign<br>ortry)<br>Y LAND |
|                | end w  |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, T       | own or Lo            | cation  |                            |                 |                                       |               | 1  | 10d. Inside City Limits                     |
|                | Maryi<br>-f sho  | tor            | MD. N/A   |  | В                  | ALTI                 | MORE  |                            |                 |                                       |               |  | 1 XYes 2 □ No                               |
|                | th the   | Director       | 10e. Street and Number  |  |                    |                      | 10f. Zip Co   | de                         |                 |                                       | 10g. Citizen  | of What Cour                                 | ntry?                                       |
|                | ath wi   | rai            | 2730 ASHLAND  |  |                    |                      | 212   |                            |                 |                                       | USA           |  |   |
| 5-0036         | 72 hours after death with the Marylend<br>"naturel", or Itame 23a or 28a-f show<br>idical Examiner must be notilied at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent B<br>Armed Forces?<br>1 Yes 2 N<br>If Yes, Give X<br>Year or Dates:   |                    |                      | Was Decedent<br>If Yes, specify<br>1 ☐ Yes 2☐       |                            |                 | fy Yes or No-<br>can, etc.)           |               | Race - Americ<br>Black, White,<br>ecify: BLA | etc.  |
| 'n             | 72   | eted           | 15. Decedent's Ed   | ducation<br>de completed)  | 1                  | 6a. Deced            | dent's Usual Or<br>kind of work di<br>DO NOT use re | ccupation<br>one during me | ost of working  |                                       | 16b. Kind     | of Business/In                               | dustry                                      |
| 2              | within<br>ene.<br>then "   | Completed      | Elementary/Secondary (0-12)   | 2 College (1-4or 5   | +)                 | life.                | DO NOT use re<br>cle:                               |                            |                 |                                       | bo            | 10   |   |
| ם<br>ס         | filed<br>Hygi<br>other   |                | 17. Father's Name (First, Middle, Last,   |  |                    |                      | 010.  |                            | ther's Name (F  | First, Middle,                        |               |  |   |
| la<br>la       | Alental  | To Be          | RALPH THAC  | KER  |                    |                      |   | C                          | LARA (          | GREEN                                 |               |  |   |
| Mary           | 2 shot<br>and h<br>le me   | 0 3            | 19a. Informant's Name/Relationship (  | Type, Print)   |                    | 19b. Mailir          | ng Address (St                                      | reet and Num               | ber or Rural F  | Route Numbe                           | r, City or To | wn, State, Zip                               | Code)                                       |
| ≥<br>o`        | s 1 and<br>f Health<br>frem 27<br>other tr   |                | ANGELA BROWN L  | EMON (co   | usin)              |                      | 3 MOR   |                            | ROAD<br>Dat     |                                       |               | E, MD.                                       |   |
| E              |  |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐   |  | cem                | etery, cren          | natory or other                                     | place)                     |                 |                                       |               | ion - City or To                             |   |
| altın          | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                | Donation 5 ☐ Other (Specification of Funeral Service Licer  | 11   | ARBU               |                      |   |                            |                 |                                       |               |  | MORE, MD.                                   |
| n              | Den Pen  | 1              | Demadene !  | 1. Scru  | 291                | CA                   | LVIN  | B. SC                      | RUGGS<br>ESTON  | FUNE                                  | RAL E         | HOME   | _21213                                      |
|                |  |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                                 | plications that caused<br>one cause on each lin  | the death. I       | Do not ent           | er the mode of                                      | dying, such a              | as cardiac or r | espiratory ar                         | rest,         | , ML   | Approximate<br>Interval Between             |
| ı              | Physician  |                | Immediate Cause (Final disease or condition   | a Athero   | sclero             | tic                  | cand:   | ovasc                      | ular            | dise                                  | asl           |  | Onset and Death                             |
|                | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as  | a consequen        | ice of):             |   | •                          |                 |                                       |               |  |   |
| į,             |  | er             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a   | a consequen        | ice of):             |   |                            |                 |                                       |               |  |   |
| V              | cuted  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             | C.   |                    |                      |   |                            |                 |                                       |               |  |   |
| Ď.             | e exection ar  | Ex             | resulting in death) Last  | Due to (or as  | a consequen        | ice of):             |   |                            |                 |                                       |               |  |   |
| 09/89          | icate be executed<br>physicien and<br>s the burial-transit   | edical         | •   | d  |                    |                      |   |                            |                 |                                       |               |  |   |
| ×              | certifii<br>nding p  | V/Me           | IF FEMALE:  | 23c. If yes, outcome   | of pregnancy       | ,                    |   |                            |                 |                                       | 23d           | . Date of delive                             | 20/   |
| XO<br>RO<br>RO | death<br>le atten  | iciar          | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live birth<br>4 ☐ Pregnant at  |                    |                      | Ectopic pregn<br>Other (specifi                     |                            |                 |                                       | 250.          | Month  | Day Year                                    |
| J.             | the ache   | Physician/M    | 1 Yes 2 No<br>9 Dunknown  | 9∐ Unknown   |                    |                      |   |                            |                 |                                       |               |  |   |
| <u>က်</u>      | w requires that the<br>been signed by the<br>should be detache   | þ              | Part II. Other significant conditions of  | contributing to death bu   | ut not resultir    | ng in the ur         | nderlying causi                                     | given in Par               | t I.            |                                       |               |  | ne cause of death?                          |
| 0              | requii   | Completed      | Dinbetes N  | (LCCCCV)   |                    |                      |   |                            |                 |                                       | -             |  | ably 4 Unknown                              |
| e<br>E         | ne la<br>has   | mp             |   |  |                    |                      |   |                            |                 | 24a. Was a<br>autop<br>perfor         | sv            | 4b. Were auto<br>prior to co<br>death?       | psy findings available mpletion of cause of |
|                | tician: The<br>certificate<br>rector, pag  | ပိ             | 25. Was case referred to medical  | 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1   |                    |                      |   | as Dia                     | ce of Death (0  | 1 Yes                                 | 2 🗆 No        | 1 X Yes                                      | 2 No  |
| =              | Physician:<br>this certific<br>al director,  | To B           | examiner?<br>1 (XYes 2 ☐ No   | Hospital: 1 Inpatie  | nt 2□ER            | /Outpatien           | t 3 DOA   | 0.11                       | Nursing Home    |                                       |               | Other (Specif                                | SCENE                                       |
| 10 E           | Attending Physician: r death. ector: After this certific by the funeral director,                                      |                | 27. Magner of Death 1 Natural 5 Pending   | 28a. Date of Injur<br>(Month, Day  | y<br>Year) 28      | b. Time of<br>Injury | 28c.  | Injury at<br>Work?         |                 | d. Describe h                         |               |  |   |
| <u> </u>       | ottendi<br>death.<br>ctor: A<br>y the fu   | cati           | 2 Accident investigation 3 Suicide 6 Could not b  |  |                    |                      |   | 1 ☐ Yes 2 [                |                 |                                       |               |  |   |
| DIVISION       | l or Al<br>after of<br>Direction by  | Certification: | 4 Homicide determined   | 28e. Place of Inju<br>building, etc  | c. (Specify)       | , rarm, str          | eet, factory, on                                    | ice                        | 281             | City or Tow                           |               | umber or Hura                                | l Route Number,                             |
|                | ne Hospitel or Attend<br>124 hours after death<br>ne Funeral Director: /   | edical C       |   | nysician: To the best of niner: On the basis of and manner sta   | examination        |                      |   |                            |                 |                                       |               |  |   |
|                | To the within 2. To the complet  | Me             | 29b. Signature and title of certifier   | *  |                    |                      | 29c. Lie  | ense numbe                 | r               | i                                     | 29d. Date si  | gned (Month,                                 | Day, Year)                                  |
|                |  |                | - high  | i mi   | ·                  |                      |   | O.C.                       | M.E.            | ]                                     | Decemb        | per 28,                                      | 2005  |
|                | H  | 1              | 30. Name and address of person who  |  |                    |                      |   | Ctroot                     | D-1+            | imora                                 | Me1           | ond 01                                       | 201   |
|                |  | to             | 31. Date filed (Month, Day, Year)   | I Milio  | ar's Signature     |                      | Penn  | orreer                     | , Dalt          | uliore,                               | naryl         | Land 21                                      | 201   |
|                | Sta<br>Registr   |                | JAN 0.3 2   |  |                    | k .                  | Gack ,  |                            |                 |                                       |               |  |   |
| DHN            | MH 17 Rev 1/20   | 001            | JAN O. O.   | WWW TO THE REAL PROPERTY OF THE | il s               | 19                   |   |                            |                 |                                       |               |  |   |

DHMH 17 Rev 1/2001

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|                     |   |                 | 1 - For State Registrar   | State of Maryland  |                                 | rtment of H  |  |   | enel () 5                               | 42481  |
|---------------------|---|-----------------|---|--|---------------------------------|--|--|---|---|--|
|                     |   |                 | Decedent's Name (First, Middle, Last)   |  |                                 |  |  | 2. Date of Death<br>Month                       |   | 3. Time of Death                                     |
|                     | Physici<br>/Medic   |                 | DR. JOSÉ L  | UIS COY-(FERI  | RER)                            | <u></u>  |  | DECEMBER  | 30, 200.                                |  |
| *.                  | Examin  |                 | 4a. Facility Name (If not institution, give str<br>Saint Joseph Me  |  | er                              | 4b. City, Town, or   | Location of Deat                         |   | 4c. County of De                        | ath<br>Cimore  |
|                     | Funeral   |                 | Social Security Number     6. Sex   | 7. Age (In yrs. la   | - 1                             | If Under 1 Year<br>Months Days                                   | If Under 24 Hrs<br>Hours Min.            | 8. Date of Birth (Month, Day,                   | Year) (                                 | irthplace (State or Foreign<br>Country)              |
|                     | Director  |                 | 140 72 0170   | <sup># 2□ F</sup> 76   | Yrs.                            |  |  | Dec 17,   | 1929                                    | Spain  |
|                     | and and   |                 | Usual Residence of Decedent  10a. State 10b. County   | 10c. City  | , Town or Lo                    | cation   |  |   |   | 10d. Inside City Limits                              |
|                     | Mary  | ō               | Maryland Baltimore  | Country  | Balti                           | mora   |  |   |   | 1 ☐ Yes 2 X No                                       |
|                     | 288<br>288  | Director        | 10e. Street and Number  | County   | ратсы                           | 10f. Zip Code  |  | 10  | g. Citizen of What                      | Country?   |
|                     | 3a or   |                 | 6602 Weymouth Cour  | +  |                                 | 2  | 1212                                     |   | Cnad                                    |  |
|                     | deat  | Funerai         | 11. Marital Status 12   | . Was Decedent Ever in U.S<br>Armed Forces?                              |                                 | Vas Decedent of Hi<br>Yes, specify Cuba                          | spanic Origin? (S                        | pecify Yes or No-                               | Spai<br>14. Race - An<br>Black, Wh      | nerican Indian,                                      |
| õ                   | or its  |                 | 1 Never Married 2 Married   | 1 ☐ Yes 2 X No<br>If Yes, Give   |                                 | Yes 2□ No  |  |   |   |  |
| Š                   | be filed within 72 hours after death with the Maryland and Hygiene. d other than "natural", or items 23a or 28s-1 ehow event, the Madical Exeminer must be notified at  | d by            | 3 Widowed 4 Divorced  | Year or Dates:   |                                 |  | Sp                                       | ain   |   | Spainish   |
| 7                   | n 72 l  | Completed       | 15. Decedent's Educa<br>(Specify only highest grade of  | tion<br>completed)   | (Give                           | lent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | luring most of wo                        | rking   | 6b. Kind of Busines                     | s/Industry   |
| 7                   | filed within 72<br>Hygiene.<br>other than "na<br>ant, the Madic   | шc              | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                                 | essor/Dep  | •  |   | Universi                                | ty Education   |
| Ö                   | Hyg<br>other<br>ent,  | Be C            | 17. Father's Name (First, Middle, Last)   |  |                                 |  |  | ne (First, Middle, M                            | aiden Sumame)                           |  |
| <u>la</u> n         | should be filed<br>and Mental Hygi<br>marked other<br>imatic event,   | To B            | José Coy Cerezo   |  |                                 |  | Cloti1                                   | lde Ferrar                                      | Alonso                                  |  |
| Maryland 21215-0036 | s 1 and 2 should i<br>f Health and Meni<br>Itam 27 is marke<br>other traumatic  |                 | 19a. Informant's Name/Relationship (Type  | , Print)   | 19b. Mailin                     | g Address (Street a  | and Number or Ru                         | ural Route Number,                              | City or Town, State                     | , Zip Code)  |
| _                   | 1 and 2<br>Health<br>am 27<br>other tr  |                 | Dr. Susanna P. Coy  | (Wife)   |                                 |  | Court,                                   | Baltimore                                       |   |  |
| 0                   | Pages 1 ar<br>nent of Hea<br>int: if Itam<br>iry or othe  |                 | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Ren   | noval from State   | metery, crem                    | sition (Name of<br>natory or other place                         | 1  |   | Oc. Location - City of                  |  |
| Baltimore,          | t Pa<br>tmen<br>tant:   |                 | 4 Donation 5 Other (Specify)  | Dru  |                                 | lge Cemet  |  | 3,2006 P  | ikesville                               | e, Maryland  |
| g                   | permit. Pages<br>Department of I<br>Importent: if Ite<br>any injury or of<br>once.  |                 | 21. Signature of Funeral Service Licensee   | roen   | M-                              | . Name and Addres<br>itche11-W                                   | liedefeld                                | l Funeral                                       | Home, In                                | С.   |
| 183                 | S. W.   |                 | Martin D. Lawson<br>23a. Part 1. Enter the disease, or complica   | n<br>tions that caused the death   | . Do not ente                   | 500 York<br>or the mode of dying                                 | Road, Bag, such as cardia                | ltimore,  | Maryland                                | 21212<br>Approximate                                 |
|                     |   |                 | shock, or heart failure. List only one  | cause on each line.  |                                 |  |  |   |   | Interval Between<br>Onset and Death                  |
|                     | Physician<br>/Medical   |                 | disease or condition resulting in death)  | ADENOCARC I  Due to (or as a consequ                                     |                                 | Or LUNG  |  |   |   |  |
|                     | Examiner  |                 | Communication line and distance   |  | ·                               |  |  |   |   |  |
|                     | D ==  | ner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequ  | ence of):                       |  |  |   |   |  |
|                     | ecute<br>and<br>trans   | Examiner        | Cause (Disease or injury that initiated events c. resulting in death) Last                                  | Due to (or as a consequ  | anae of                         |  |  |   |   |  |
| 60,                 | cate be executed<br>physician and<br>the burial-transit   |                 |   | Due to (or as a consequ  | ierice or).                     |  |  |   |   |  |
| 98760               | physicate<br>physics<br>s the   | dical           | d   |  |                                 |  |  |   |   |  |
| ×                   | leath certifi<br>attending I<br>I for use as  | /Me             | IF FEMALE: 23b. Was decedent pregnant   | :. If yes, outcome of pregnar  | ncy                             |  |  |   | 23d. Date of d                          | elivery  |
| Вох                 | death<br>a atter<br>d for u   | iciar           | in the past 12 months?  | 1☐Live birth 2☐Fetal<br>4☐Pregnant at time of de                         |                                 | Ectopic pregnancy Other (specify)                                |  |   | Month                                   | Day Year   |
| O.                  | t the by the tacher   | hys             | 9 Unknown   | 9□ Unknown   |                                 |  |  |   |   |  |
| S,                  | The law requires that the death certificate be executed tie hes been signed by the attending physician and page 2 should be detached for use as the burial-transit      | by Physician/Me | Part II. Other significant conditions contri  | buting to death but not resu   | Iting in the ur                 | nderlying cause give   | en in Part I.                            |   |   | to the cause of death?                               |
| D.C                 | w require<br>been si<br>should b  | ted             |   |  |                                 |  |  | 1 X Yes   | 2 □No 3 □ I                             | Probably 4 Unknown                                   |
| Records,            | law r<br>les be   | Completed       |   |  |                                 |  |  | 24a. Was an autopsy                             | prior to                                | autopsy findings available<br>completion of cause of |
|                     |   | Con             |   |  |                                 |  |  | perform<br>1 ☐ Yes 2                            | ed? death?<br>No 1 ☐ Ye                 | s 2 No   |
| Vital               | ician<br>certifi<br>ector   | Be              | 25. Was case referred to medical examiner?  | spital:  |                                 | Othe   | ar                                       | ath (Check only one                             |   |  |
| 0                   | Phys<br>this<br>ral dir   | OT:             | 1 ☐ Yes 2 No  | 1 Mainpatient 2 ☐ 8<br>28a. Date of Injury                               | 28b. Time of                    | 1 3LI DOA  | 4   Nursing r                            | lome 5 ☐ Residen                                |   | pecify)  |
| Division of         | ding f<br>th.<br>After<br>funer   | tion            | 1 ■Natural 5 □ Pending 2 □ Accident investigation   | (Month, Day Year)  | Injury                          | Work   | k?<br>Yes 2∐No                           |   | injury socialise                        |  |
| <u> S </u>          | Atten<br>er deat<br>ector:<br>by the  | ifica           | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At ho   |                                 | eet, factory, office   |  |   |   | Rural Route Number.                                  |
| á                   | s afte  | Certification:  | 4 - Hollicide   | building, etc. (Specify  | )                               |  |  | City or Town,                                   | State)                                  |  |
|                     | To the Hospital or Attending Physician: which 24 hours after death. To the Funeral Director: After this certification the Funeral Director. After the funeral director; | Medical         | 29a. Certifier 1 Certifying Physic (Check only one)   | r: On the best of my known: On the basis of examinational manner stated. | wledge, death<br>ion and/or inv | occurred at the time<br>restigation, in my op                    | ne, date and place<br>pinion, death occu | e, and due to the cau<br>arred at the time, dat | use(s) and manner<br>e and place, and d | as stated.<br>ue to the cause(s)                     |
|                     | To thi<br>within<br>To the  | Me              | 29b. Signature and title of certifier   |  |                                 | 29c. License   | number                                   | 29  | d. Date signed (Mo.                     | nth, Day, Year)                                      |
| -                   | 1   |                 | V Kon   | ~ (  |                                 | D 37   | 254                                      |   | 12/31/                                  | 20   |
| (                   |   |                 | 30. Name and address of person who com  | pleted cause of death (Item  | 23a) (Type, I                   | Print)   |  |   |   |  |
|                     | 0   |                 | BOON P. LIM. M.I  |  |                                 | RIVE, T  | OWSON,                                   | MARYLAN   | D 21204                                 |  |
|                     | Sta<br>Registi  |                 | 31. Date filed (Month, Day, Year)  JAN 0 3 2006   | 32. Registrar's Signat   | ure Ange                        | Es   |  |   |   |  |

|  | -              | For<br>State<br>Registrar   | State of   | Marylan   |                                       | artmen<br>rtificate                               |                        |                                       | and M                    | lental Hygi                                      | ene ()                    | 05  | 4248   |
|--|----------------|---|--|---|---------------------------------------|---|------------------------|---------------------------------------|--------------------------|--|---------------------------|---|--|
| Physicia<br>/Medica  | al -           | 1. Decedent's Name (First, Middle,  | Dem  | inic  | le.                                   | 41-03-  |                        |                                       | 10.01                    | 2. Date of Death<br>Month<br>12                  | Day 27                    | Year<br>2005                              | 3. Time of Death 06:00                       |
| Examine  |                |   | RE POT   | TOMA-   | last birthday)                        |   | toma                   | Location of                           |                          | 8. Date of Birth (Month, Day,                    | M                         | ontgom  9. Birthp                         | lace (State or Fore                          |
| Director   |                | 109-14-1088  Usual Residence of Decedent  10a. State 10b. County  | 1□ M 2€OXF   |   | Yrs.<br>y, Town or Lo                 | ocation   |                        |                                       |                          | 02-03-   | 1920                      | 5New                                      | York  Od. Inside City Lim  1 □ Yes 2 🔀       |
| within 72 hours after death with the Maryland ane. then "natural", or Itama 23a or 28a-f show the Madrel East-litter into the notified at                                    | ai Director    | MD Mont;<br>10e. Street and Number<br>4413 Muncaster  | gomery<br>Mill Rd.   |   | 1413 Mt                               | 10f. Zip  |                        | 2085                                  |                          | Rockvill   |                           | of What Cour                              |  |
| ours after dea<br>rel', or Itama<br>Examiner in  | by Funeral     | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced  | 12. Was Deced Armed Ford  1 □ Yes 2 If Yes, Give Year or Dat | ces?<br>2⊠No  |                                       | Was Deced<br>If Yes, spec                         |                        | spanic Orig<br>n, Mexican<br>Specify: | gin? (Spe<br>, Puerto    | ecify Yes or No-<br>Rican, etc.)                 | В                         | lace - Amend<br>lack, White,<br>cify: Whi | etc.   |
| filed within 72 hours<br>Hygiene.<br>Sther than "natural"<br>ent, It e M. or cal Ex.   | Completed      | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)  |  | 4or 5+)   | (Give                                 | dent's Usua<br>kind of wor<br>DO NOT us<br>emaker | k done d<br>e retired  | turing most                           | of worki                 | ng 1   |                           | Business/Ind                              | dustry                                       |
| strould be titel and Mental Hyg marked othe amatic event,  | To Be C        | 17. Father's Name (First, Middle, L<br>Ivan A. Djenee:  19a. Informant's Name/Relationshi   | Ef   |   | 10h Maili                             | Address   | (Street of             | 0.                                    | lga Y                    | (First, Middle, M<br>Youssopo<br>I Route Number, | vich                      |   | G-7-1  |
| pamit. Pages I and 2 should be lied with Department of Health and Menial Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, II a Mone. |                | Christopher Bla   | ackwall/so   | 20b. P  |                                       | fill R  | ld. I                  | lavert                                | town                     | PA 1908  | 3                         | n - City or To                            |  |
| permit. Pag<br>Department<br>Important: I<br>any injury o  |                | 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service L  | ecify)   | Ch  | - China                               | 2. Name and<br>Ran p                              | d Addres               | s of Facilit                          | y<br>& Cre               | 30-2005<br>emation<br>Spring                     | Servi                     | tsvill<br>ce                              | e MD   |
| cate be<br>physicia<br>the bur   | dicai Examiner | 23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last | a. Due to (o   | used the death of line.  O C V  or as a consequence as a | uence of):                            | DC K  |                        |                                       |                          | r respiratory arre                               | st,                       |   | Approximate Interval Between Onset and Death |
| that the death certificated by the attending posterored for use as   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown   |  | th 2 ☐ Feta<br>nt at time of d  | Ideath 3[                             | ∃Ectopic pro<br>∃ Other (spe                      |                        |                                       |                          |  |                           | Date of delive<br>Month                   | ery<br>Day Year                              |
| v requires mar<br>been signed b<br>should be deta  | P              | Part II. Other significant condition  | s contributing to dea  | ath but not res   | ulting in the u                       | nderlying ca                                      | ause give              | en in Part I.                         |                          |  | acco use co               |   | ne cause of death'                           |
| ircien: Inelawr<br>certificate has be<br>rector, page 2 sh   | Completed      |   |  |   |                                       |   |                        |                                       |                          |  | ed?<br>No                 | prior to cor<br>death?                    | psy findings availant pletion of cause 22 No |
| his in di  | n; To Be       | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of   |   | ER/Outpatier<br>28b. Time o<br>Injury |   | A Other                | er: 4 🔀 Nu                            | rsing Hor                | ne 5 ☐ Resider<br>28d. Describe how              | nce 6 □C                  |   | 1)   |
| death<br>death<br>ctor:<br>/ the   | Certification: | 2 Accident investigs 3 Suicide 6 Could not determin   | ot be 28e. Place of  | of Injury - At ho<br>g, etc. (Specif  | ome, farm, sti                        | М   | 10                     | Yes 2 □ 1                             | -                        | 28f. Location (Str.<br>City or Town,             |                           | mber or Rura                              | l Route Number,                              |
| Hosp<br>24 hou<br>Fune<br>tely fii   | edicai         | 29a. Certifying (Check only one)  1 ☑ Certifying 2 ☐ Medical E  | Physician: To the t<br>xaminer: On the bas<br>and manne      | sis of examina  | wledge, deat<br>ition and/or in       | h occurred a<br>vestigation,                      | at the tim<br>in my of | ie, date and<br>pinion, deal          | d place, a<br>th occurre | and due to the car<br>ed at the time, da         | use(s) and lete and place | manner as st<br>e, and due to             | ated.<br>the cause(s)                        |
| ,  | Σ              | 29b. Signature and title of certifier   | ).   | of death (tr  | 22a\ /T -                             | Do  |                        | number<br>456 (                       | r<br>5                   | 29   |                           | ned (Month, I                             | Day, Year)                                   |
| Stat<br>Registra   |                | 30. Name and address of person w  | 122  | of death (Iten  | 1 701                                 | Print)  |                        |                                       |                          | 230 TOL  |                           |   | -12  |

|                            |   |                     | for State   | State of Maryl  | •                                   |   |  | Mental Hygi                                     | ene<br>2005                                  | 1.21.83  |
|----------------------------|---|---------------------|---|---|-------------------------------------|---|--|---|--|--|
|                            | ¢ 1 1 1   |                     | Registrar  1. Decedent's Name (First, Middle,   | Last)   | Ce                                  | rtilicate                                 | of Death   | 2. Date of Death                                | J. N6+ 0 0 0                                 | 3. Time of Death                               |
| 2                          | Physici<br>/Medic   |                     | MARVIN  | Н   |                                     | DAV I                                     | [S   | Month<br>December                               | Day Year - 28, 2 CC5                         | 12: 30A M                                      |
| 1                          | Examin  |                     | 4a. Facility Name (If not institution,  |   |                                     |   | wn, or Location of Dea   | th  | 4c. County of Death                          | 1  |
|                            | · · · · · · · · · · · · · · · · · · ·   | yaki 🕌              |   | L HOSPITAL  S. Sex 7. Age (In   | yrs. last birthday                  |   | TIMORE  Year If Under 24 Hrs   | 8 Date of Birth                                 | N/A  | nplace (State or Foreign                       |
| 8                          | Funeral Director  |                     | 212-20-4115   | 1 M 2 □ F   | 87 Yrs.                             |   | ays Hours Min  | 8. Date of Birth (Month, Day, 1971)             | 918 Co                                       | MD   |
|                            | pu &  |                     | Usual Residence of Decedent  10a. State 10b. County   | 100   | . City, Town or L                   | ocation                                   |  |   |  | 10d. Inside City Limits                        |
|                            | Maryla<br>-f eho  | to                  | MD  |   | BALTIMOR                            |   |  |   |  | 1 Yes 2 □ No                                   |
|                            | th the  | irec                | 10e. Street and Number  |   |                                     | 10f. Zip Co                               | de   | 10  | g. Citizen of What Co                        | untry?   |
|                            | ath will  | rai D               | 830 WEST 40th   |   |                                     |   | 211  |   | U.S.A.                                       |  |
| 036                        | perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show any righty or other treumatic event, it a Medical Examplear must be inclified at ADEs. | by Funeral Director | 11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☑ Widowed 4 □ Divorced                      | 12. Was Decedent Ever<br>Armed Forces?<br>d 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 |                                     | Was Decedent If Yes, specify              | t of Hispanic Origin? (5<br>Cuban, Mexican, Puer<br>No <i>Specify:</i> | Specify Yes or No-<br>to Rican, etc.)           | 14. Race - Amer<br>Black, White<br>Specify:  |  |
| 5                          | 72 ho   | eted                | 15. Decedent's<br>(Specify only highest   |   | (Give                               | dent's Usual O                            | tone during most of wo   | rking   | 6b. Kind of Business/I                       | ndustry  |
| 21215-0036                 | within<br>ane.<br>then  | Completed           | Elementary/Secondary (0-12)   | College (1-4or 5+)<br>5+  | PHYS                                | DO NOT use n                              | etired)  |   | MEDICINE                                     |  |
|                            | Hygid<br>other  | Be Co               | 17. Father's Name (First, Middle, L.  |   | 11113.                              | LOIAN                                     | 18. Mother's Na  | me (First, Middle, Ma                           |  |  |
| /lan                       | Menta be<br>Menta<br>mrked<br>attic ev  | To B                | WILLIAM   |   | DAVIS                               |   | KATHRY   | N   | SIL  | ESKY   |
| Maryland                   | 12 sho<br>h and<br>7 ie m<br>treum  |                     | 19a. Informant's Name/Relationshi   | 19  |                                     |   | treet and Number or R  |   |  |  |
|                            | Healt<br>tem 2  |                     | ELLEN DAVIS-AQUI  20a. Method of Disposition  |   | b. Place of Disp                    | osition (Name o                           | AND ROAD #   |   | Oc. Location - City or 1                     |  |
| altimore,                  | Pages<br>nent of<br>int: If i   |                     | 1 ☑ Burial 2 ☐ Cremation 3<br>4 ☐ Donation _5 ☐ Other (Spe                                      | HI  | NSHE EMU<br>TTZ-CHA                 | omatory`or other<br>INAH<br>FM            |  | 0/2005 1  | BALTIMORE,                                   | MD   |
| Balti                      | epartin<br>oports<br>ny inju  |                     | 21. Signature of Fundal Service C   | cense   |                                     | 2. Name and A                             | ddress of Facility   | SOL LEVINS                                      | SON & BROS                                   | ., INC.  |
|                            | 205 8 9   |                     | 222 Part Feter the disease or o   | omplications that caused the  | death. Do not or                    |   | EISTERSTOW   |   |  | MD 21208 Approximate                           |
| 2                          | Physician   |                     | 23a. Part1. Enter the disease or c<br>shock, or heart failure. List o<br>Immediate Cause (Final |   |                                     |   |  |   | Ι,   | Interval Between<br>Onset and Death            |
|                            | /Medical  |                     | disease or condition<br>resulting in death)   | a. Ongesti  |                                     | art                                       | Failure<br>Diseas  |   |  | 2 years  |
|                            | Examiner  | _                   | Sequentially list conditions if any, leading to immediate                                       | , Corona  | -                                   | ten                                       | Diseas   | 2   |  | 40 years                                       |
| λ/                         | nsit  | Examiner            | cause. Enter Underlying Cause (Disease or injury  | Due to (or as a cor   | is equence or):                     | 0   |  |   |  | 7  |
| oʻ                         | be executed<br>sician and<br>burial-transit   | Exal                | that initiated events<br>resulting in death) Last   | Due to (or as a con   | sequence of):                       |   |  |   |  |  |
| 8760,                      | icate be<br>physicia<br>s the bu  | lical               |   | d.  |                                     |   |  |   |  |  |
| 9                          | eath certific<br>attending p<br>for use as I  | /Med                | IF FEMALE:  | 23c. If yes, outcome of pro   | egnancy                             |   |  |   | 23d. Date of deli                            |  |
| . Box                      | D 0 D   | Physician/Medical   | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 ☐ No                          | 1 Live birth 2 □<br>4 □ Pregnant at time  | Fetal death 3                       | □Ectopic pregr<br>□ Other (s <i>pecil</i> |  |   | Month  | Day Year                                       |
| P.O.                       | that the de<br>ned by the a<br>detached f   | Phys                | 9 ☐ Unknown   | 9□ Unknown  |                                     |   |  | 02- 0:4-4                                       |  |  |
|                            | The law requires that the tite has been signed by the bage 2 should be detache  | by                  | Part II. Other significant condition  | s contributing to death but no  | resulting in the                    | underlying caus                           | e given in Part I.   | 1 Tes   | cco use confribute to                        | bably 4 Unknown                                |
| 9<br>0<br>0                | e law re<br>has bee<br>je 2 sho   | Completed           |   |   |                                     |   |  | 24a. Was an autopsy                             | 24b. Were au                                 | topsy findings available ompletion of cause of |
| E E                        |   | Соп                 |   |   |                                     |   |  | performe  |  | 2□ No  |
| <u> </u>                   | Physician: Th<br>r this certificate<br>ral director, pag  | Be                  | 25. Was case referred to medical examiner?  | Hospital:   | 2□ EB/0                             | 2000                                      | Othor  | ath (Check only one)                            |  |  |
| ō                          | g Phys<br>er this<br>eral dii   | n: To               | 1 ☐ Yes 2 No<br>27. Manner of Death   | 1 Inpatient  28a. Date of Injury (Month, Day Yea                                  | 2 ER/Outpatie                       |   | Injury af Work?  | 28d. Describe how                               | ce 6 Other (Spec                             | ity)   |
| sion                       | Attending I<br>r death.<br>ector: After<br>by the funer   | atlo                | Natural 5 Pending 2 Accident investiga  | tion  | a injury                            | М   | 1 Yes 2 No   |   |  |  |
| Division of Vital Records, | P # 를 드   | Certification:      | 3 Suicide 6 Could no<br>4 Homicide determin   |   |                                     | treef, factory, of                        | ffice  | 28f. Location (Stre<br>City or Town,            | et and Number or Ru<br>State)                | ral Route Number,                              |
|                            | To the Hospital within 24 hours a To the Funeral completely filled  | edicai (            | 29a. Certifier 1 Certifying (Check only one)  | Physician: To the best of my<br>xaminer: On the basis of examiner stated.         | knowledge, dea<br>mination and/or i | th occurred at to<br>nvestigation, in     | he time, date and plac<br>my opinion, death occ                        | e, and due to the cau<br>urred at the time, dat | ise(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)                     |
|                            | To the within 2 To the complet  | Me                  | 29b. Signature and title of certifier   |   |                                     | 29c. Li                                   | cense number   | 296   | d. Date signed (Month                        | , Day, Year)                                   |
|                            |   |                     | CARKONTO  | Echinemere,   | M.D.                                | D   | 00 6317  | 6 De  | ecomber-                                     | 28, 2005                                       |
|                            | 13  |                     | 30. Name and address of person w  |   |                                     |   |  |   |  | 28, 2005<br>Maryland.                          |
| 80                         | Sta   | ite                 | 31. Date filed (Month, Day, Year)   | Nwachinem<br>Registrar's S  |                                     | U. U.                                     | UIDN IX/EN   | novial H  | DZbitus                                      | viery land.                                    |
| <i>*</i> .                 | Registi   |                     | JAN 0 3 2   | 2006 Blowner.   | 15 April                            | SALL)                                     |  |   |  |  |

Please Type or Print in Black Indelible lpk. Ensure All Copies Are Legible. Amend item#18, perFH, G851, I-3-03 TI

|                                 |   |                | For State  | State of   | Marylar                                 | nd / Depa                        | artment of H   |                              | nd Mental Hy                                      | giene                     | 005                                 | 42484  |
|---------------------------------|---|----------------|--|--|---|----------------------------------|--|------------------------------|---|---------------------------|-------------------------------------|--|
|                                 |   |                | Registrar  1. Decedent's Name (First, Middle, La                             | etl  |   | Cei                              | rtilicate of L                                       | Jeain                        | 2. Date of D                                      | Reg. No.                  | 000                                 | 3. Time of Death                                 |
| П                               | Physici   |                | Myron Evans,   | _  |   |                                  |  |                              | Month   | Day                       |                                     | 10.127.  |
|                                 | /Medic<br>Examin  |                | 4a. Facility Name (If not institution, give                                  |  | nber)                                   |                                  | 4b. City, Town, or                                   | Location o                   | Death   |                           | 22,2005<br>County of Death          | 2  |
|                                 |   |                | Northwest Hospi  | tal  |   |                                  | Randal   | lsto                         | wn  | В                         | altimo                              | re   |
| * 3.                            | Funeral   |                | ,  | Sex  | 7. Age (In yrs.                         | last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days                       | If Under 2<br>Hours          | Min. (Month, D                                    | a <i>y, Year)</i>         | 9. Birth                            | place (State or Foreign<br>ntry)                 |
|                                 | Director  |                | 216-82-2113 Usual Residence of Decedent                                      |  | 36                                      |                                  |  |                              | June  | 16,1                      | 969 Ma:                             | ryland   |
|                                 | yland   |                | 10a. State 10b. County   |  |   | ty, Town or Lo                   |  |                              |   |                           |                                     | 10d. Inside City Limits                          |
|                                 | B Mar   | ctor           | Maryland $N/I$   | <i>A</i>   |   | Balti                            | nore   |                              |   |                           |                                     | Y⊡Yes 2□No                                       |
|                                 | or 28   | Director       | 10e. Street and Number   |  |   |                                  | 10f. Zip Code  |                              |   | •                         | zen of What Cou                     | ntry?  |
|                                 | s 23a   |                | 5205 Denmore A   | 1  | dost Euros in 11                        | 10 112                           | 212  |                              | in? (Specify Vac at N                             | USA                       |                                     | oon Indian                                       |
|                                 | ter de  | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☑ Married                             | 12. Was Dece<br>Amed Fo                          | ces?                                    |                                  | If Yes, specify Cuba                                 | n, Mexican                   | in? (Specify Yes or N<br>, Puerto Rican, etc.)    | 1                         | 14. Race - Ameri<br>Black, White,   | etc.   |
| 036                             | al', o  | ρ              | 3 Widowed 4 Divorced   | If Yes, Giv<br>Year or Da                        | 0                                       |                                  | 1 ☐ Yes XIXNo  | Specify:                     |   |                           | <sub>Spec</sub> Blac                | K.   |
| 21215-0036                      | 72 ho   | Completed      | 15. Decedent's E<br>(Specify only highest gr                                 |  |   | (Give                            | dent's Usual Occupa                                  | luring most                  | of working  | 16b. Kir                  | nd of Business/In                   | dustry   |
| 12                              | within ane.   | mpl            | Elementary/Secondary (0-12)  | College (1                                       | -4or 5+)                                |                                  | DO NOT use retired<br>le Sale                        | )                            |   | Self                      | -Emplo                              | ved  |
| ς<br>σ                          | Hygie<br>Hygie<br>ther t  |                | 12th grade  17. Father's Name (First, Middle, Last                           | )  |   | WIIO                             |  | 18. Mothe                    |   | 1                         |                                     |  |
| an                              | lid be<br>lental<br>ked c   | To Be          | Michael Evans  |  |   |                                  |  | Glady                        | r's Name (First, Middle<br>Monroe<br>'S Monroe    |                           |                                     |  |
| ary                             | and N   | _              | 19a. Informant's Name/Relationship   |  | ,                                       | 19b. Maili                       | ng Address (Street a                                 | ind Numbe                    | r or Rural Route Numb<br>Baltimo                  | er, City or               | Town, State, Zip                    | Code) 1 215                                      |
| <b>∑</b>                        | and 2<br>eelth<br>m 27 I  | 13             | Crystal Weaver   | Evans  |   |                                  |  | AVE                          |   |                           |                                     |  |
| Baltimore, Maryland             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Ptyglene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-1 ehow any figury or other traumatic event. The Madical Exacting frank the mollish at Once. |                | 20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐                      |  |   |                                  | esition (Name of<br>matory or other place<br>Cemetel | e) 12                        | Date 2.7-0.5                                      |                           | downe.                              | own, State<br>Maryland                           |
| 蕇                               | iit. Pa<br>artmer<br>ortent<br>njury  | . 6            | 4 ☐ Donation 5 ☐ Other (Special Service Lice                                 |  | pic.                                    |                                  |  |                              |   |                           |                                     |  |
| Ba                              | Depre Impo  | 6 6            | Men de   | rris   |   | 5                                | 240 Rei:   | sters                        | stown Rd  | Balt                      | imore,                              | eral Home<br>Md 21215                            |
|                                 |   |                | 23a. Part1. Enter the disease, or com-<br>shock, or heart failure. List only | plications that c                                | aused the deat                          | th. Do not en                    | er the mode of dyin                                  | g, such as                   | cardiac or respiratory                            | arrest,                   |                                     | Approximate<br>Interval Between                  |
| N.                              | Physician   |                | Immediate Cause (Final disease or condition                                  | 10   | rain si                                 | tom 1                            | nfarctio   | N                            |   |                           |                                     | Onset and Death                                  |
|                                 | /Medical<br>Examiner  |                | resulting in death)  | Due to (   | or as a consec                          | quence of):                      |  |                              | . 1   |                           |                                     |  |
| 18 <sup>2</sup> ).              | A. S.   | 7              | Sequentially list conditions, if any, leading to immediate                   | b. Due to (                                      | ultipl                                  | e ora                            | an syste   | m to                         | alure   |                           |                                     |  |
| TV                              | uted<br>3<br>ansit  | Examiner       | Cause (Disease or injury   |  | taphl                                   |                                  | al bact  | evem                         | ia  |                           |                                     |  |
| ή<br>O                          | an and<br>rial-tra  | Exa            | that initiated events<br>resulting in death) Last                            | C. Due to (                                      | or as a consec                          | quence of):                      | wi Duoi  | Orein                        | 1100  |                           | +                                   |  |
| 8760,                           | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit   | dical          | •  | d  |   |                                  |  |                              |   |                           |                                     |  |
| မှ                              | ertific<br>ding p   | Med            | IF FEMALE:   | 220 H 1100 011                                   |   |                                  |  |                              |   |                           |                                     |  |
| Вох                             | eath certifi<br>attending  <br>  for use as   | slan.          | 23b. Was decedent pregnant in the past 12 months?                            |  | inth 2 ∏ Feta<br>ant at time of c       | al death 3                       | Ectopic pregnancy Other (specify)                    |                              |   | 2                         | 3d. Date of delive<br>Month         | ery<br>Day Year                                  |
| o.                              | that the de<br>ed by the<br>detached  | Physician/Me   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9☐ Unkno   |   | Jean 30                          |  |                              |   |                           |                                     |  |
| ري<br>ح                         | is that<br>jned b<br>e deta   | by PI          | Part II. Dther significant conditions  | contributing to de                               | ath but not res                         | sulting in the u                 | nderlying cause give                                 | en in Part I.                | 23e. Did  | tobacco us                | se contribute to t                  | he cause of death?                               |
| ğ                               | w requires that<br>s been signed t<br>should be det   | ed k           | End stage rend   | ul dise  | ase                                     |                                  |  |                              | 1   | Yes 2                     | □No 3 toProt                        | pably 4 Unknown                                  |
| ပိုင                            | law ri<br>las be  | Completed      | Hypertension   |  |   |                                  |  |                              | 24a. Was  | psv                       | 24b. Were auto                      | ppsy findings available<br>impletion of cause of |
| <u>~</u>                        | : The<br>cate h   | Con            | Anemia of acute  | and e  | pronic                                  | inflar                           | nmation  |                              | perf<br>1□ Yes                                    | 2 No                      | death?                              | 2 🗆 No   |
| <u> </u>                        | sician<br>certifi<br>rector   | Ве             | 25. Was case referred to medical examiner?                                   | Hospital:  |   | 1500                             | ot all DOA Othe                                      | 00                           | of Death (Check only                              |                           |                                     |  |
| o                               | Phys<br>or this<br>oral di  | 1; To          | 1 ☐ Yes 2 ☑ No<br>27. Manyler of Death                                       |  | npatient 2<br>of Injury<br>h, Day Year) | ER/Outpatier<br>28b. Time o      | IL SU DOA  | 4 🗀 1901                     | sing Home 5 Res                                   |                           |                                     | (y)  |
| ion                             | ttending<br>death.<br>stor: Afte<br>/ the fune  | atlor          | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation                         |  | h, Day Year)                            | Injury                           |  | (?<br>Yes 2 □ N              | 10  |                           |                                     |  |
| Division of Vital Records, P.O. | l or Atte<br>after de<br>Directo<br>i in by th  | Certification; | 3 ☐ Suicide 6 ☐ Could not t<br>4 ☐ Homicide determined                       | 286. Place                                       | of Injury - At h                        | iome, farm, sti                  | eet, factory, office                                 |                              |   | (Street and<br>wn, State) | Number or Rura                      | al Route Number,                                 |
|                                 | urs aff   |                |  |  |   |                                  |  |                              |   |                           |                                     |  |
|                                 | Hospital<br>24 hours a<br>Funeral I   | Medical        | 29a. Certifier 1 YCertifying P<br>(Check only 2 Medical Exa                  | nysician: To the<br>miner: On the ba<br>and mann | isis of examina                         | owledge, deat<br>ation and/or in | h occurred at the tim<br>vestigation, in my or       | ie, date and<br>pinion, deat | d place, and due to the<br>h occurred at the time | cause(s) and              | and manner as s<br>place, and due t | tated.<br>the cause(s)                           |
|                                 | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  | Me             | 29b. Signature and title of certifier  |  |   |                                  | 29c. License   | number                       |   |                           | signed (Month,                      |  |
|                                 |   |                | > & Boston   | MD   |   |                                  | 0 28   | 3462                         |   | Decei                     | mber 2                              | 2,2005   |
|                                 | 3   |                | 30. Name and address of person who   | completed caus                                   | e of death (Iter                        | 1 11                             |  | 40                           | 1 1 1 2   |                           |                                     |  |
|                                 |   |                | 31. Date filed (Month, Day, Year)  |  | thwes                                   |                                  | spital   | Kan                          | dallstou  | m,                        | Marylar                             | 12 21133   |
|                                 | Sta<br>Registr  | ate            |  |  |   |                                  |  |                              |   |                           |                                     |  |

CPM05-08767 Marni

Please Type or Print in Black Indelible Ink. Ensure All Coples Are Legible.

| ta Elb   | orn                 | Unpend item# 2  1 - For State Registrar   | 3a,27,28a<br>State                            | of Marylai   |  | 7/06 TI<br>artmen<br>ertificat                    |                           |  | ınd M                   |   | iene       | 005                                | 42485  | 5   |
|--|---------------------|---|---|--|--|---|---------------------------|--|-------------------------|---|------------|------------------------------------|--|-----|
|  | sician              | 1. Decedent's Name (First, Middle, Marnita K  | Last)   | E1born   |  |   |                           |  |                         | 2. Date of Deat<br>Month<br>Decembe                         | Day        | , 2005                             | 3. Time of Death 18:30                             | м   |
|  | edical<br>miner     | 4a. Facility Name (If not institution,  |   | umber)   |  |   | Town, or                  | Location of                            |                         |   | 4c. C      | ounty of Death                     | -l   | _   |
| Fune   | ral                 | 1   | way<br>.Sex<br>1□M 2□XF                       | 7. Age (In yrs   |  |   |                           | If Under 2<br>Hours                    | 24 Hrs.<br>Min.         | 8. Date of Birth<br>(Month, Day                             |            | 9. Birthp                          | place (State or Forei                              | ign |
| Direct   | tor                 | 221-38-9368 Usual Residence of Decedent   | 10 M 2 Q                                      | 43   | Yrs.   |   |                           |  |                         | 4-23-19   | 62         | DE                                 |  |     |
| aryland<br>show  |                     | 10a. State 10b. County MD Wicomi  | 60  | 10c. C   | ty, Town or L  | ocation<br>Lisbur                                 | v                         |  |                         |   |            | 1                                  | 0d. Inside City Limi                               |     |
| with the M<br>a or 28a-f   | Directo             | 10e. Street and Number 6221 Strawberry  |   |  |  | 10f. Zip  |                           | 01                                     |                         | 1   | 0g. Citize | en of What Coul                    |  |     |
| paritificities, invary failed at 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Importants: If item 27 is marked on ther then natural; or items 23a or 28s-f show any Injury or other tranmatic event. The Medical Exeminar must be notified at   | by Funeral Director |   | 12. Was Dec<br>Armed F<br>1  Yes<br>If Yes, G | cedent Ever in U<br>orces?<br>2 (X)No<br>iive                | J.S. 13  | Was Deced<br>If Yes, spec                         |                           | spanic Orig<br>n, Mexican,<br>Specify: | jin? (Spe<br>, Puerto l | cify Yes or No-<br>Rican, etc.)                             |            | I. Race - Americ<br>Black, White,  |  |     |
| 2-UUSO 72 hours at natural; or   | ted b               | 3 Widowed 4 Divorced  15. Decedent's  | Year or i                                     |  | 16a. Dec   | edent's Usua                                      | al Occupa                 | ition                                  |                         |   |            | of Business/In                     |  |     |
| within 7   | Completed           | (Specify only highest Elementary/Secondary (0-12) 1 2   |   | (1-4or 5+)   | life.  | e kind of wo<br>DO NOT us<br>fice N               | se retired                | )                                      | of workir               | ng  | Ala        | rm Comp                            | any  |     |
| other the  | Be                  |   | ist)  |  | 02   |   |                           |  | r's Name                | (First, Middle, I   | Maiden Si  | umame)                             |  |     |
| y land y land hould be filt Mental H harked oth  | 10                  | wardon willey   |   |  | 401.11   |   | /2:                       |  |                         | Beal  | 0)         |                                    |  | _   |
| Mal<br>nd 2 st<br>elth and<br>27 Is n  | 177                 | 19a. Informant's Name/Relationship<br>Shelby Elborn /   |   |  |  | -   |                           |  |                         | Route Number<br>Salisbur                                    |            |                                    |  |     |
| mit. Pages 1 a partment of He portant: If item violation or other violations or other violations.  |                     | 20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe  |   | State Sha  | Place of Disposers | osition (Nar<br>Prinatory or of<br>IIII<br>ial Pa | ne of<br>ther plac<br>urk | 1:                                     | 2/30                    | 10=   |            | ation - City or To                 | own, State   |     |
| permit. Departm  | once.               | 21. Sign have of Funeral Service Li   | Tules   | M013   |  | 22. Name an                                       | d Addres                  | s of Facility<br>ve SW                 | Sin<br>Gle              | gleton<br>n Burnie  | Fune:      | ral Hom<br>21061                   | e P.A.   |     |
| Physicia<br>/Medic   |                     | 23a. Part1. Enter the disease, or co<br>shock, or heart failure. List or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. Aceta                                      | caused the dea<br>each line.                                 | and Dip  |   |                           |  |                         |   | est,       |                                    | Approximate<br>Interval Between<br>Onset and Death |     |
| certificate be executed XT certificate be executed XT certificate by sicien and XT certificate and XT certif | و<br>م              |   | с.  | o (or as a conse   |  |   |                           |  |                         |   |            |                                    |  |     |
| death certific e attending p   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown   | 1 Live  | utcome of pregr<br>birth 2 ☐ Fet<br>gnant at time of<br>nown | al death 3   | □Ectopic pr<br>□ Other (sp                        |                           |  |                         |   | 23         | d. Date of delive<br>Month         | ery<br>Day Year                                    |     |
| law requires that the as been signed by the 2 should be detached   | ed by P             | Fait II. Ditter significant condition   | s contributing to                             | death but not re   | sulting in the   | underlying c                                      | ause give                 | n in Part I.                           |                         |   | oacco use  |                                    | ne cause of death?<br>pably 4 □Unknov              | ٧n  |
| The lay  |                     |   |   |  |  |   |                           |  |                         | 24a. Was autops<br>perform<br>1 Yes 2                       | y          |                                    | psy findings availab<br>impletion of cause o       |     |
| Of VICAL Physician: 1 this certificat ral director, p.   | o Be                | 25. Was case referred to medical examiner?  | Hospital:                                     | 2  | lance live   |   | Othe                      |  |                         | (Check only on  |            | 7                                  | COLVE  | _   |
| sg Physter this  | n: To               | 1)∑QYes 2 □ No  27. Manner of Death 1 □ Natural 5 □ Pending   |   | Inpatient 2<br>of Injury<br>oth, Day Year)                   | ER/Outpatie<br>8b. Time<br>Injury  |   | 8c. Injury<br>Work        | 4 🗆 1408                               | -                       | ne 5 🗌 Reside<br>8d. Describe ho                            |            |                                    | y) SCENE   |     |
| To the Hospital or Attending Physicial Control of Within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral  | Certification:      | 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin   | t be ed 28e. Place build                      |  | 6:30 F   | М   | 10,                       |  | 2                       | ubject in<br>28f. Location (St<br>City or Town<br>Salisbury | reet and I | Number or Rura                     | al Route Number,<br>awberry Way                    |     |
| Hospi<br>24 hour<br>Funer  | edical              |   | Physicien: To the aminer: On the              | ne best of my kn   | owledge, dea<br>ation and/or i   | th occurred<br>nvestigation                       | at the tim                | e, date and<br>inion, death            | i place, a              | and due to the ca   | use(s) ar  | nd manner as s<br>lace, and due to | tated.<br>o the cause(s)                           |     |
| To the within To the   | Me                  | 29b. Signature and title of certifier   | m 1 1   | 0 -  |  | 290   |                           | number                                 | T-2                     |   |            | signed (Month,                     |  |     |
|  |                     | 30. Name and address of person w  | no completed cau                              | use of death (Ite  |  |   |                           | O.C.M                                  |                         |   |            | mber 27                            |  |     |
| 1063   | State               | 31. Date filed (Month, Day, Year)   | 32.   | Registrar's Sign   |  |   |                           | <u>et, B</u>                           | artii                   | more, Ma  | aryLa      | ana 2120                           | )I   |     |
| 100  | istrar              | JAN 0   | 2008  | All Tour   | K.   | frank   | e                         |  |                         | 1073  |            |                                    |  |     |
| DHMH 17 Rev  | v 1/2001            |   |   |  |  | 0"  |                           |  |                         |   |            |                                    |  |     |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:30 AM PAUL ALLEN ERDMAN, JR. DECEMBER 31. 2005 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical ( 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nov 16, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1<del>√</del> M 2□ F 75 215-28-3570 Director Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 No Idlewylde Maryland Baltimore County Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itams 23a or 21239 USA 1024 St. Albans Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after Hygiene. 1 MYes 2 No If Yes, Give 148-152 Year or Dates: 148-152 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 White þ Specify: 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Systems Technician Telecommunications other t permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 Ie marked othrany injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian G. Magee Paul Allen Erdman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1024 St. Albans Road, Baltimore, Maryland 21239 Shirlev L. Erdman (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 1/4/2006 Baltimore, Maryland 21. Signatura of Funeral Service Licenses

Martin D. Lawson 22. Name and Address of Facility Mitchell Wiedefeld Funeral Home, Inc. PIACULT D. Lawson

6500 York Road, Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 2007. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC COLON CANCER Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 K Natural 1 Tes 2 No death. М investigation 2 Accident completely filled in by the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funerel C the Hospital 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31/05 W D 47625 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 EY M.D. 7E RICHARD A. O'MALL 31. Date filed (Month, Day, Year) Charles of State JAN 0 3 2006 Registrar

Amend item#11, periff, G851, 1-3-06 II State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** STEIN 2000 PECEMBER 30 11:50P M 2005 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (Not institution, give street and number) 4c. County of Death Examiner HOSPITAL RANDACCSTOWN BACTIMORE NORTH WEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 069730049 048 5. Social Security Number Birthplace (State or Foreign Country) PA 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F 87 185-07-6184 Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 TYes 2 NO BALTIMORE Directo BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 4020 ESSEX ROAD death Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No þ 3 Widewed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CHEMIST CHEMISTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental KLINE le marked **EPSTEIN** BECKY HYMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: if Item 27 le
eny Injury or other trau 4020 ESSEX ROAD - BALTIMORE, MD 21207 JOSEPHINE EPSTEIN/WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG. 01/02/2006 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 al 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** HEART FAILURE ONGESTINE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Completed by Physician/Medical the 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral is 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and Alle Certifier 29c. License number 29d. Date signed (Month, Day, Year) 757722 M-D DECEMBER 30 2005 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NONTH WEST HESPITAL LEONARD RICHARDSON MD 5401 OLD COURT RUAP RANPACUSTOWN MP 21132 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 3 2008 Registrar

|                     |   |                  | For State Registrar  | State of M   |                       | d / Depa                       |   | t of H                   | ealth a                   | and M      | •                                    |                              | 05                      | 42488                            |
|---------------------|---|------------------|--|--|-----------------------|--------------------------------|---|--------------------------|---------------------------|------------|--------------------------------------|------------------------------|-------------------------|----------------------------------|
|                     |   |                  | 1. Decedent's Name (First, Middle,   | Last)  |                       |                                |   |                          |                           |            | 2. Date of De<br>Month               | ath                          | V                       | 3. Time of Death                 |
|                     | Physici<br>/Medio   |                  |  | INUCAI   |                       |                                |   |                          |                           |            | 12                                   | 30                           | Year<br>2005            | 12:27a <sup>M</sup>              |
| ž.,                 | Examir  | ier              | 4a. Facility Name (If not institution,                                       |  | )                     |                                | 4b. City,                               | Town, or                 | Location o                | of Death   |                                      | 4c. Co                       | unty of Death           |                                  |
|                     |   |                  | 5409 Wild Turk 5. Social Security Number                                     |  | ge (In yrs. la        | act birthday)                  | Co<br>If Under                          | 1umb:                    | ia<br>If Under            | 24 Hrs     | 9 Data of Bis                        |                              | ward                    | <del></del>                      |
| п                   | Funeral Director  |                  | 171-10-0760  | to sex 7. A  | 91                    | Yrs.                           | Months                                  | Days                     | Hours                     | Min.       | 8. Date of Bir (Month, Date of 1/25) | ny, Year)                    |                         | place (State or Foreign<br>ntry) |
|                     | ס   |                  | Usual Residence of Decedent  |  |                       |                                |   |                          |                           |            | 01/23                                | /1914                        | Mas                     | sachusetts                       |
|                     | show  | _                | 10a. State 10b. County   | - 1  | 1                     | Town or Lo                     |   |                          |                           |            |                                      |                              |                         | 10d. Inside City Limits          |
|                     | Ba-f  | ecto             | MD Howar   |  | Co                    | lumbi.                         |   |                          |                           |            |                                      |                              |                         | 1 ⊈Yes 2 □ No                    |
|                     | be filed within 72 hours after death with the Maryland<br>hal Hygiene.<br>od other than "natural", or Items 23a or 28a-1 show<br>avent, the Mudical Exam or must be motified at | Funeral Director | 10e. Street and Number 5414 Wild Turk  | cev Lane   |                       |                                | 10f. Zip                                |                          | 21044                     | <b>.</b>   |                                      |                              | of What Cou             | ntry?                            |
|                     | leath<br>ns 23  | eral             | 11. Marital Status   | 12. Was Deceden  | t Ever in U.S         | 3. 13.                         | Was Deced                               | lent of His              | spanic Ori                | gin? (Spe  | city Yes or No                       | USA<br>14                    | Race - Ameri            | can Indian                       |
| ထ                   | after dea   | 표                | 1 ☐ Never Married 2 ☐ Marrie   | Armed Forces   | ?                     |                                |   |                          |                           |            | cify Yes or No<br>Rican, etc.)       |                              | Black, White,           | etc.                             |
| 8                   | ral', c   | l by             | 3 Widowed 4 Divorced   | If Yes, Give<br>Year or Dates:                                     |                       |                                | 1 □ Yes 2                               | 2 LXNo                   | Specify:                  |            |                                      | Sp                           | ec <i>ify:</i> Whi      | te                               |
| 5                   | 72 h<br>natu  | Completed        | 15. Decedent'<br>(Specify only highest                                       | s Education<br>grade completed)                                    |                       | 16a. Deced<br>(Give            | dent's Usua<br>kind of wor<br>DO NOT us | l Occupa<br>k done di    | tion<br>uring most        | t of worki | ng                                   | 16b. Kind                    | of Business/In          | dustry                           |
| 121                 | within ene.   | dm               | Elementary/Secondary (0-12)  | College (1-4or   | 5+)                   |                                | oo norus<br>cher                        | e retired)               |                           |            |                                      | 17.4                         |                         | _                                |
| d 2                 | filed withi<br>Hygiene.<br>other than   |                  | 17. Father's Name (First, Middle, L  |  |                       | read                           | cher                                    |                          | 18. Mothe                 | r's Name   | (First, Middle,                      |                              | ucatio                  | n                                |
| Maryland 21215-0036 | 2 should be f<br>and Mental I<br>is marked of<br>aumatic ave  | To Be            | Thomas J. Finu   |  |                       |                                |   |                          |                           |            | hine                                 |                              |                         |                                  |
| ary                 | s 1 and 2 should<br>f Health and Men<br>itam 27 is merke<br>othar traumatic   | -                | 19a. Informant's Name/Relationsh   | ip (Type, Print)   |                       | 19b. Mailir                    | ng Address                              | (Street a                | n <i>d Numb</i> e         | or or Rura | Route Number                         | er, City or To               | wn, State, Zip          | Code)                            |
|                     | 도 등 2 를 도   |                  | Kiyo N. Finuca   | me/wife  |                       | 5409                           | Wild                                    | Turl                     | key L                     | ane        | Columb:                              | ia MD                        | 21044                   |                                  |
| ore                 | 0 0   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation                          | 3 □Removal from State  |                       | ace of Dispo<br>metery, cren   | sition (Nam<br>natory or of             | ne of<br>ther place      |                           |            | ate                                  | 20c. Locati                  | ion - City or To        | own, State                       |
| Ë                   | Pages<br>Iment of<br>tant: If it<br>jury or o   |                  | `4 □Donation 5 □ Other (Sp   | ecify)   | Che                   | sapeal                         |   |                          |                           |            | 0/2005                               |                              | 1tsvi1                  | le MD                            |
| Baltimore,          | permit. Pag<br>Department<br>Important: I<br>any injury o   |                  | 21. Signature of Funeral Service L   | 4  | 135                   |                                |   |                          |                           |            | emation<br>r Sprin                   |                              |                         |                                  |
|                     |   |                  | 23a. Part1. Enter the disease, or of shock, or heart failure. List of        | complications that cause<br>only one cause on each                 | d the death.<br>line. | . Do not ent                   | er the mode                             | e of dying               | , such as                 | cardiac o  | r respiratory a                      | rrest,                       |                         | Approximate<br>Interval Between  |
|                     | Pnysician   |                  | Immediate Cause (Final disease or condition                                  | _a End St  | age P                 | arkin                          | son's                                   | Dise                     | ease                      |            |                                      |                              |                         | Onset and Death                  |
|                     | /Medical<br>Examiner  |                  | resulting in death)  | Due to (or a   |                       |                                |   |                          |                           |            |                                      |                              |                         |                                  |
|                     | EE grade  | <u>6</u>         | Sequentially list conditions, if any, leading to immediate                   | b. — Due to (or a  | a conseq <i>u</i> e   | ence of):                      |   |                          |                           |            |                                      |                              |                         |                                  |
| /                   | uted<br>d<br>ansit  | Examiner         | cause. Enter Underlying<br>Cause (Disease of injury<br>that initiated events | <b>(</b>   |                       |                                |   |                          |                           |            |                                      |                              |                         |                                  |
| o,                  | an an<br>rial-tr  |                  | resulting in death) Last   | Due to (or a   | s a conseque          | ence of):                      |   |                          | -                         |            |                                      |                              |                         |                                  |
| 8760,               | The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit              | ical             |  | d  |                       |                                |   |                          |                           |            |                                      |                              |                         |                                  |
| 9                   | entifica<br>ling ph<br>e as t   | Physiclan/Med    | IF FEMALE:   |  |                       |                                |   |                          |                           |            |                                      | 1                            |                         |                                  |
| Вох                 | eath certific<br>attending p  | lan/             | 23b. Was decedent pregnant in the past 12 months?                            | 23c. If yes, outcome   | 2 Fetal               | death 3                        | Ectopic pre                             |                          |                           |            |                                      | 23d.                         | Date of delive<br>Month | ory<br>Day Year                  |
| P.O.                | at the de<br>by the a<br>tached   | ysic             | 1 □ Yes 2√√No<br>9 □ Unknown   | 4☐Pregnant a<br>9☐ Unknown   | it time or dea        | atn 5L                         | Other (spe                              | эсіту)                   |                           | -          |                                      |                              |                         |                                  |
|                     | res that i<br>igned by<br>be deta   |                  | Part II. Other significant condition   | ns contributing to death   | but not resul         | lting in the ur                | nderlying ca                            | use give                 | n in Part I.              |            | 23e. Did to                          | obacco use                   | contribute to the       | he cause of death?               |
| Vital Records,      | w requires<br>been sign<br>should be  | ed by            |  |  |                       |                                |   |                          |                           |            | 1 🗆 1                                | ∕es 2 <b>⊠</b> ×             | o 3∏Prob                | pably 4 Unknown                  |
| 000                 | aw reals bee  | Completed        |  |  |                       |                                |   |                          |                           |            | 24a. Was                             | an 2                         | 4b. Were auto           | psy findings available           |
| Ä                   | The I   | E O              |  |  |                       |                                |   |                          |                           |            | autop<br>perfo                       | rmed?                        | death?                  | mpletion of cause of             |
| /ita                | sician: Th<br>certificate<br>rector, pag  | Be C             | 25. Was case referred to medical examiner?                                   |  |                       |                                |   |                          | 26. Place                 | of Death   | (Check only o                        |                              |                         |                                  |
| of \                | Physician:<br>this certific<br>ral director.  | မ                | 1 ☐ Yes 2 No   | Hospital: 1 ☐ Inpat  |                       | R/Outpatien                    |   |                          | - ( 1401                  |            | ne 5 🗌 Resid                         |                              |                         | Son's<br>Residence               |
| S L                 | ding F<br>h.<br>After<br>funera   | lon:             | 27. Manner of Death  Natural 5 Pending                                       |  | ay Year)              | 28b. Time of<br>Injury         | M 28                                    | Bc. Injury<br>Work?      |                           |            | 8d. Describe h                       | now injury od                | curred                  |                                  |
| Division            | deat<br>ctor:<br>y the  | licat            | 2 Accident investiga 3 Suicide 6 Could no                                    | ot be 290 Place of In  | iury - At hon         | ne farm stre                   |   |                          | es 2□ñ                    |            | 98f Location /5                      | Street and N                 | umber or Bure           | l Route Number,                  |
| οį                  |   | Certification:   | 4 Homicide determin  | building, e  | tc. (Specify)         | io, rain, sin                  | ou, idolory,                            | Onice                    |                           |            | City or Tou                          | vn, State)                   | ander of rigia          | ir Noate Namber,                 |
|                     | To tha Hospital or within 24 hours afte to tha Funaral Discompletely filled in  | edical C         | 29a. Certifier   1 Certifying (Check only one)   2   Medicel E               | Physicien: To the besi<br>xeminer: On the basis of<br>and manner s | of examination        | rledge, death<br>on and/or inv | occurred a                              | at the time<br>in my opi | e, date and<br>nion, deat | d place, a | nd due to the o                      | cause(s) and<br>date and pla | manner as si            | tated. the cause(s)              |
|                     | To tha I within 2. To tha I complet   | Me               | 29b. Signature and title of certifier  |  | _                     |                                |   | License                  |                           |            |                                      | _                            | gned (Month,            |                                  |
| •                   | 1   |                  | I Was a  | 1D, FCC  |                       |                                | D                                       | 36                       | 845                       | )          |                                      | Dec.                         | 30,                     | 2005                             |
|                     | 15  |                  | 30. Name and address of person w   |  |                       |                                |   |                          |                           |            |                                      |                              |                         |                                  |
|                     | Sta   | 10               | Mai-Chi Nguyen 31. Date filed (Month, Day, Year)                             | n 7350 Grac  | e Dr.                 | Colum<br>re                    | bia M                                   | D 21                     | 044                       |            |                                      |                              |                         |                                  |
| [8x                 | Registr   |                  | JAN 0 3  | 34. Regist   | JAK.                  | 100                            | T.                                      |                          |                           |            |                                      |                              |                         |                                  |
|                     |   |                  | V 0 0 .  |  |                       | 9                              |   |                          |                           |            |                                      |                              |                         |                                  |

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ACI MORE 1 Year | If Under 24 Hrs. Days | Hours | Min. Ve MORE Birthplace (State or Foreign Country) 6. Sex 10 M 2 ☐ F Age (In yrs. last birthday) If Under 1 **Funeral** Months 6 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menlait Hyglene. Important: If tien 27 is marked other than "neturel", or items 23e or 28e-f show any injury or other treumatic event, Item Medical Exam Let must be rollified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director TIMORY TIMOR 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ST Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Pryes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 20 No Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 nnc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wherine TIMOVE 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licersee 22. Name and Address of Facility BALTIMORE MD any ir 8800 HARFORD EVANS FUN ERAC CHAPEL 23a. Part 1. Enter the disease, or complications that caused the ceath, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ cate has been sig , page 2 should b 3 Probably 4 ☐Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No certificate l 1 Tyes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) 2 No Hospital: Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide target Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) Panay btis X
31. Date filed (Month, Day, Year) Ba 8113 Har ford Kd MD 32. Registrar's Signature State Registrar

|                   |   |                | Amend                                   | item#3,pe                                    | 1498,6851 J. 13  | -plack-in                               | delible ink.   | Ensure All                                       | Copies A                               | re Legib                            | le.   |
|-------------------|---|----------------|---|--|--|---|--|--|--|-------------------------------------|---|
|                   |   |                | For 1 _ State                           |  | State of Maryla  |   | artment of H   |  |  | 200                                 | 5 42490   |
|                   |   |                | Registrar                               |  |  | Cei                                     | unicate of L   | Jeani  | Re<br>2. Date of Death                 | g. No.                              | 3. Time of Death  |
|                   | Physici   | an             | 1. Decedent's Nam                       | ne (First, Middle, Las                       | 000  | GIEN                                    | 17141414   | 16   | Month<br>December                      | Day Y                               | ear 2,260   |
|                   | /Medic  |                | STUNI                                   | () FIE                                       | RCE  | acci                                    | JDINNIN  |  | Recorder                               | 4c. County of                       |   |
|                   | Examin  | er             | CIIAA                                   | (If not institution, give                    |  | SIPTAL                                  | 4b. City, Town, or   |  |  |                                     |   |
| _                 |   |                | E Social Sociation                      | GROVE HI                                     |  | s. last birthday)                       | If Under 1 Year  | If Under 24 Hrs.                                 | 8. Date of Birth                       |                                     | JTGOMERY  D. Birthplace (State or Foreign                     |
|                   | Funeral<br>Director   |                | 219-73                                  |  | M 2□F  | Yrs.                                    | Months Days  | Hours Min.                                       | (Month, Day,                           | 2005                                | Country)<br>MAKYLAND  |
|                   |   |                | Usual Residence                         |  |  |   |  | 1  | <i></i>                                |                                     | Miniquinos  |
|                   | New New   |                | 10a. State                              | 10b. County                                  | 10c. (   | City, Town or Lo                        | cation   |  |  |                                     | 10d. Inside City Limits                                       |
|                   | Mer   | 호              | MD                                      | MONTE  | 10 MERY  |   | OLNE   | Y, MAR   | YLAND                                  |                                     | 1 1 1 Yes 2 □ No  |
|                   | hours effer death with the Merylend<br>turel', or Itema 23a or 28e-f ahow<br>al Examinar must be notified at  | Director       | 10e. Street and No                      | umber  |  |   | 10f. Zip Code  | 2  | 10                                     | g. Citizen of Wh                    | at Country?   |
|                   | 15 wil  |                | 2210 1                                  | WINTERG                                      | ARDEN W  | AY                                      |  | 20832  |  | us                                  | 5A  |
|                   | 8 6   | Funeral        | 11. Marital Status                      |  | 12. Was Decedent Ever in<br>Armed Forces?              | U.S. 13.                                | Was Decedent of His<br>f Yes, specify Cubar                      | spanic Origin? (Spental)<br>n, Mexican, Puerto F | cify Yes or No-<br>licen, etc.)        |                                     | American Indian,<br>White, etc.                               |
| õ                 | a a a   |                |   | mied 2 Married                               | 1 Yes 2 No   |   | 1 ☐ Yes 2 No   | Specify:   |  | Specify:                            | . 0 .1  |
| Š                 | 72 hours<br>"natural",<br>dicel Exe   | d by           | 3 ∐ Widowed                             | 4 Divorced                                   | Year or Dates:   |   |  |  |  | 01 16'- 1 16 0                      | WHITE   |
| <u> </u>          | in 72 h   | Completed      | (Spe                                    | 15. Decedent's Ed<br>ecify only highest gra- | ucation<br>de completed)                               | (Give                                   | dent's Usual Occupa<br>kind of work done d<br>DO NOT use retired | uring most of workir                             | g 1                                    | 6b. Kind of Busi                    | ness/industry   |
| 21213-0030        | withir<br>ene.<br>then  | 를              | Elementary/Sec                          | condary (0-12)                               | College (1-4or 5+)                                     | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | INFAN-   |  |  |                                     |   |
| N<br>B            | be flied<br>itei Hygi<br>id other<br>event,   |                | 17. Father's Name                       | (First, Middle, Last)                        |  |   | 11017110   | 18. Mother's Name                                | (First, Middle, M                      | aiden Sumame)                       |   |
| 2                 | dentei<br>Kad o   | o Be           | ANDRE                                   | 7  | RTER GLE   | NDINI                                   | LING   | 1-AURI   | A MICI                                 | JEILE                               | SEEVERS   |
| Maryiand          | ahoul<br>mark<br>merk   | ဥ              |   | Name/Relationship (7                         |  |   | ng Address (Street a   | nd Number or Rura                                | Route Number,                          | City or Town, St                    |   |
| <u>≥</u>          | trau  |                | ANDREW                                  | 01.  | 1 -  | FR 221                                  | O WINT   | FREARI   | 0.1 1.0                                | ALO PA                              | JEY MD  |
| Ď                 | f Hee   |                | 20a. Method of Di                       |  |  | . Place of Dispo                        | 7  | D  | ate 2                                  | 0c. Location - Ci                   | ty or Town, State   |
| Бантітог          | 00-   |                |   | 2 Cremation 3 ☐<br>5 ☐ Other (Specify        |  | resapea                                 | 1 0 1  | 1 31   | 06 B                                   | ollevill                            | a MD  |
|                   |   |                |   | uneral Service Licen                         |  |   | Name and Addres  | e of Facility                                    | Line                                   |                                     | CIND  |
| ä                 | permit. Depenting mports any Injure.  |                | 3/                                      | The Atolia                                   | voun   |   | Rapp Fun   | eral & Ci<br>Av Silve                            | emation                                | Service<br>MD 200                   | e<br>010  |
|                   |   |                | 23a. Part 1. Enter                      | the disease, or comp                         | olications that caused the de                          | eath. Do not ent                        |  |  |  |                                     | Approximate<br>Interval Between                               |
|                   |   |                | Immediate Cause                         | (Final                                       | one cause on each line.                                | 54,00                                   | CR   |  |  |                                     | Onset and Death   |
|                   | Priysician<br>/Medical  |                | disease or condit<br>resulting in death |  | a. Due to (or as a cons                                |   |  |  |  |                                     | December  |
|                   | Examiner  |                |   |  | Pulmor   | 1274                                    | hupe:  | y tensio   | N                                      |                                     | 27,2005   |
|                   |   | 6              | Sequentially list of if any, leading to | conditions,<br>immediate                     | b. Due to (or as a cons                                | equence of):                            |  |  | - 8                                    |                                     | December  |
|                   | d d d   | Examin         | Cause (Disease of that initiated even   | or injury                                    | Necroti  | 2113                                    | Entero   | Colitis  | Tota                                   | 115                                 | 27,2005   |
| ĵ                 | be executed<br>sician end<br>buriel-trensit   | Exa            | resulting in death                      | Last   | Due to (or as a cons                                   |   |  |  |  |                                     |   |
| 760,              | ysicie  | Cal            |   | •  | d  |   |  |  |  |                                     | Servery of  |
| 9                 | or Attanding Physician: The law requires thet the deeth certificate siter deeth.  Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be deteched for use as the | Physician/Medi | IF FEMALE:                              |  |  |   |  |  |  |                                     |   |
| X<br>O<br>D       | th cer<br>endir   | 2              | 23b. Was decede                         |  | 23c. If yes, outcome of pred<br>1 ☐ Live birth 2 ☐ Fe  |   | Ectopic pregnancy  |  |  | 23d. Date of Month                  | •   |
| D.                | deed of to  | 를<br>B         | in the past 1                           | No   | 4☐Pregnant at time o                                   |   | Other (specify)  |  |  | Mont                                | Day real  |
| r<br>Ö            | et the de<br>by the<br>steched  | چ              | 9 □ Unknow                              | olida o e se de de la                        |  | round) S                                | 11.00.00   |  | 00 - Distanti                          |                                     |   |
| Ś                 | ea the  | 2              | Part II. Other sign                     | ANUVI  | ontributing to death but not r                         | esulting in the u                       | nderlying cause give   | n in Part I.                                     | 239. Did (008                          | ٠.                                  | ute to the cause of death?  ☐ Probably 4 ☐Unknown             |
| ב                 | w require<br>been si<br>ahould t  | D D            | -                                       | 717.9717                                     |  |   |  |  | I L. Tes                               | 2000 3                              |   |
| or Vital Records, | as be   | e d            |   |  |  |   |  |  | 24a. Was an autopsy                    | pric                                | re autopsy findings available<br>or to completion of cause of |
| Ì                 | The la  | Completed      |   |  |  |   |  |  | perform                                | ed? dea                             | ath?<br>]Yes 2□No   |
| Ē                 | sician: 1<br>certifice<br>frector, p  | Be (           | 25. Was case refe                       | erred to medical                             |  |   |  | 26, Place of Death                               |  | 1                                   |   |
| <u>-</u>          | yslo<br>lis ce  | 2              |   | No   | Hospital: 1 Inpatient 2                                |   |  | 4 Linuising non                                  | ne 5□Resider                           | ice 6 □Other                        | (Specify)   |
| 0                 | ding Phys<br>h.<br>After this<br>funerel dir  |                | 27. Manner of Dea                       | ath<br>5 ☐ Pending                           | 28a. Date of Injury<br>(Month, Day Year,               | 28b. Time of Injury                     | f 28c. Injury<br>Work  | at 2   | 8d. Describe how                       | v injury occurred                   |   |
| 0                 | deeth.<br>ctor: A<br>y the fu   | cat            | 2 Accident                              | investigation 6 □ Could not be               |  |   |  | res 2 □ No                                       |  |                                     |   |
| DIVISION          | or Attandeter death<br>Director:  | Certification; | 3 Suicide 4 Homicide                    | dataminad                                    | 28e. Place of Injury - A<br>building, etc. (Spe        |   | eet, factory, office   | 2  | 8f. Location (Stre<br>City or Town,    |                                     | or Rurai Route Number,  |
| 2                 | To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by  |                |   |  |  |   |  |  |  |                                     |   |
|                   | To the Hospital of within 24 hours of To the Funeral D completely filled in   | Medical        | 29a. Certifier<br>(Check only           | 1 ☑ Certifying Ph<br>2 ☐ Medical Exam        | ysician: To the best of my liner: On the basis of exam | nowledge, deat<br>ination and/or in     | h occurred at the tim<br>vestigation, in my op                   | e, date and place, a<br>inion, death occurre     | nd due to the car<br>d at the time, da | use(s) and mann<br>e and place, and | er as stated.<br>d due to the cause(s)                        |
|                   | the hin 2 the the mpiet   | Zed<br>Aed     | one)                                    | ed sella of contition                        | and manner stated.                                     | ·                                       | 29c License  | number   | 20                                     | d Date signed /                     | Month Day Year)   |
|                   | 5 <u>\$</u> 5 9   | -              | 290, Signature an                       | and of continor                              |  |   | D00  | 57940  | 2                                      | 12/29                               | 7/05  |
|                   |   |                |   | 0  |  |   |  | · · ·  | 2 11 2                                 | 7011                                | ,   |
|                   |   |                | 30. Name and ad                         | dress of person who                          | completed cause of death (I                            | tem 23a) (Type,                         | Print)   | ckville  | MD                                     | 20000                               |   |
|                   | 1   |                | 7707                                    | onth Day Voorl                               | completed cause of death (I                            | nature                                  |  | ,  |  | 2000                                |   |
|                   | Sta<br>Regist   | ate<br>rar     |   |  |  |   |  |  |  |                                     |   |
|                   |   |                |   | IAN 0 3 29                                   | 6  | 18 008                                  |  |  |  |                                     |   |
| DH                | MH 17 Rev 1/2   | :001           |   |  | de s   | 0                                       |  |  |  |                                     |   |

|                     |   | •              | 1- State of Maryland / Depart Registrar Certifi  | tment of Health and N<br>ficate of Death  | Mental Hygier   | 2005 62691   |
|---------------------|---|----------------|--|---|---|--|
|                     | Physici   | an             | 1. Decedent's Name (First, Middle, Last)  Charles Vanderwerken Grunwell  |   | 2. Date of Death<br>Month<br>12-25-20                         | 3. Time of Death 2020 M  |
|                     | /Medic<br>Examin  |                |  | b. City, Town, or Location of Death<br>Bethesda   | 1   | dc. County of Death  Montgomery  |
|                     | Funeral<br>Director   |                |  | If Under 1 Year If Under 24 Hrs.<br>Months Days Hours Min.                                  | 8. Date of Birth (Month, Day, Yea 03-16-19                    | 9. Birthplace (State or Foreign<br>Country)<br>Wawhington DC                             |
|                     | Maryland  | tor            | 10a. State 10b. County 10c. City, Town or Locati MD Montgomery Silver S  |   |   | 10d. Inside City Limits 1 ∑Yes 2 □ No  |
|                     | h with the  | al Director    | 10e. Street and Number<br>14400 Homecrest Rd.  | 10f. Zip Code 20906   |   | Citizen of What Country?<br>USA  |
| 960                 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "naturel", or iteme 23s or 28s-f ehow eumatic event, the Marylest Examiner must be motified at | by Funeral     | Armed Forces? If Ye 1 ★☑ Never Married 2 ☐ Married 1 ★☑ ★Yes 2 ☐ No ₩₩ŢŢ   | s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto<br>] Yes 2™No Specify: | ecify Yes or No-<br>Rican, etc.)                              | 14. Race - American Indian,<br>Black, White, etc.<br>Specify: White                      |
| Maryland 21215-0036 | od within 72 hogiene.   | Completed      | (Specify only highest grade completed) (Give kind  | nt's Usual Occupation<br>I'd of work done during most of work<br>NOT use retired)<br>LeT    | ing 16b.  | Kind of Business/Industry  Private   |
| land                | uld be file<br>Aental Hy<br>rked oth<br>tic event   | To Be (        | 17. Father's Name (First, Middle, Last) Charles V. Grunwell  |   | e (First, Middle, Maide<br>et Elizabe                         | en Sumame)<br>th Vandenbergh   |
| Mary                | nd 2 sho<br>alth and h<br>27 is ma<br>r treuma  |                | 19a. Informant's Name/Relationship (Type, Print) Barbara Meredith 'Nicholas/daugh 9601   | Address (Street and Number or Rur<br>Language Language Language)                            | al Route Number, City<br>ington MD                            | y or Town, State, Zip Code)<br>20895   |
| Baltimore,          | ages 1 a<br>ant of Hea<br>nt: If item<br>y or othe  |                | 20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)   | on (Name of tory or other place)  |   | Location - City or Town, State Bethesda, MD  |
| Baltir              | permit. Pages 1 and 2 should be Department of Health and Menta importent: If Item 27 is marked any injury or other treumatic evones.  |                | 21. Signature of Funeral Service Licensee Moo382 22. N.  | lences 12-<br>lame and Address of Facility<br>Rapp Funeral & C<br>933 Gist Av Silve         | remation S  | ervices  |
| Ī                   | Physician<br>/Medical<br>Examiner   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.   |   |   | Approximate<br>Interval Between<br>Onset and Death                                       |
| 8760,               | icate be executed physician and s the burial-transit  | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of): |   |   |  |
| O. Box 6            | ath certif<br>ttending<br>or use as   | Physician/Mec  |  | ctopic pregnancy<br>ther (specify)  |   | 23d. Date of delivery<br>Month Day Year  |
| rds, P.             | quires that the de<br>n signed by the a<br>uld be detached i  | ρ              | Part II. Other significant conditions contributing to death but not resulting in the under   | erlying cause given in Part I.  |   | o use contribute to the cause of death?  |
| al Records,         |   | Completed      |  |   | 24a. Was an autopsy performed 1 Yes 2 X N                     | 24b. Were autopsy findings available prior to completion of cause ot death?  1  Yes 2 No |
| Division of Vital   | ding Phys<br>h.<br>After this<br>funeral dii  | ation: To Be   | 2 - Accident   | 3□ DOA Other: 4□ Nursing Ho   | th Check only one<br>me 5 ☐ Residence<br>28d. Describe how in |  |
| <u>SX</u>           | To the Hospitel or Attan within 24 hours after deatl To the Funerel Director: completely filled in by the   | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)   |   | City or Town, Sta   |  |
|                     | To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in   | Medical        | 29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowled a death on the basis of examination and/or invest and manner stated.   | referred at the time, date and place, stigation, in my opinion, death occurr                | and due to the course<br>red at the time, date a              | e) and limited as stated and place, and due to the cause(s)                              |
|                     | To To COUT  | 2              | 29b. Signature and vitte of certifier  | 29c. License number 18  | 29d. C  | ecember 27,200   |
|                     | 13  |                | 30. Name and address of person who completed cause of death (Nem 23a) Type, Print G. CHANSUAN T. IIII VOE  | over Pro  | 04407   | ecember 27,200,<br>Ructure 2085  |
| 24                  | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  JAN 0 3 2006  | ie e  |   |  |

Gramvell Charles

2020

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:00 P M Mary Catherine Giannerini December 27, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 7, 1921 Oak Crest Care Center Baltimore 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 84 Pennsylvania 204-03-7545 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Modical Examiner man be notified at 1 Yes 2 No Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 317N 8810 Walther Blvd. 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, It a Misals 2006. Elementary/Secondary (0-12) College (1-4or 5+) 8 n/a <u>Restaurant Owner</u> Hospitality 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Paul Corfidi Catherine Paoli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Michael J. Giannerini, Jr. (Son) 1431 Providence Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 1 | Burial 2 | Cremanon 5 | Buryar (Specify) Entembrent Aprraine Park Mausoleum 12/31/2005 Baltimore Maryland 21. Signature of Furieral \$ 22. Name and Address of Facility 21204 Ruck Towson Funeral Hone, Inc. 1050 York Road Towson, Md. 23a. Part1. Enter the diseas . . . complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. . . . tonly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Due to (or as a onsequence of): /Medical resulting in death) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examine attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by t page 2 should be detact Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No giannerini 24a. Was an autopsy performed 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) Medical Certification: To 27110 1 🗌 Yes the funeral dir 28c. Injury at Work? 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗍 Homicide 29a. Certifier 🞾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month. Dav. Year) 01 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) We Druce Dumenil 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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|                     |   |                | 1 - For<br>State<br>Registrar  | State of M                                       | laryland                       |                                | artment o  |                |                             | nd M      | R  | eg. No:       | 05                | 42493  |
|---------------------|---|----------------|--|--|--------------------------------|--------------------------------|--|----------------|-----------------------------|-----------|--|---------------|-------------------|--|
| ı                   | Physici   | an             | Decedent's Name (First, Middle,  | Last)  |                                |                                |  |                |                             |           | <ol><li>Date of Deat<br/>Month</li></ol> | h<br>Day      | Year              | 3. Time of Death                               |
| y.                  | /Medic  | cal            |  | ter  | Gerh                           | no1d_                          | 45 Oit T-  |                | Ati                         | D N       | Decembe                                  |               |                   | 11:02 P <sup>M</sup>                           |
| 4                   | Examin  | ier            | 4a. Facility Name (If not institution,   |  | 7                              |                                | 4b. City, To   |                |                             |           |  |               | ty of Death       |  |
|                     | Funeral   |                | Riderwood  5. Social Security Number   |  | ge (In yrs. la                 | ast birthday)                  | If Under 1 Y   | ear            | Sprin<br>If Under 24        |           | 8. Date of Birth                         |               | tgome             | ry<br>place (State or Foreign                  |
| ı                   | Director  |                | 218-10-7254  | 1 <b>X</b> M 2□F                                 | 87                             | Yrs.                           | Months D   | ays            | Hours                       | Min.      | 8. Date of Birth (Month, Day, Feb 4,     | Year)<br>1918 | Cour              | y Land   |
|                     | p ,   |                | Usual Residence of Decedent  |  | T 40- 0:-                      | Ŧ                              |  |                |                             |           |  |               |                   |  |
|                     | anyla<br>shov   | 2              | 10a. State 10b. County   |  | Too. City                      | r, Town or Lo                  |  |                |                             |           |  |               | ] 1               | 10d. Inside City Limits<br>1 ☐ Yes 2 X No      |
|                     | the M   | Director       | Maryland Balt  10e. Street and Number  | imore  |                                | Tows                           | On<br>10f. Zip Co                                    |                |                             |           |  | 0-04          | / N# + 0          |  |
|                     | with a or   | 급              |  | 011-   |                                |                                |  |                |                             |           | "  | Og. Citizen o |                   | ntry?  |
|                     | death   | Funeral        | 107 B Versaille  | 12. Was Deceden                                  | t Ever in U.S                  | S. 13.                         |  | L204           |                             | n? (Spe   | cify Yes or No-<br>Rican, etc.)          | US<br>14. R   | A<br>ace - Americ | can Indian,                                    |
| 9                   | after or ite  |                | 1 ☐ Never Married 2 ☐ Marrie   | Armed Forces  1 XYes 2 1 1 Yes, Give             |                                |                                |  |                |                             | Puerto I  | Rican, etc.)                             | Bi            | ack, White,       | etc.   |
| 903                 | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>Alcal Examilinet mast be notified at                                  | d by           | 3 X Widowed 4 □ Divorced   | Year or Dates:                                   |                                |                                | 1 ☐ Yes 2 🔀  | ĮΝο            | Ѕресіту:                    |           |  | Spec          | Whit              | te   |
| 5-0                 | within 72 hours after death with the Marylan<br>jiene.<br>r than "natural", or items 23a or 28a-f show<br>It e Maralcal Examiliner mast be multified at | Completed      | 15. Decedent's<br>(Specify only highest  | Education<br>grade completed)                    |                                | (Give                          | dent's Usual O<br>kind of work of                    | lone di        | urina most c                | of workii | ng                                       | 16b. Kind of  | Business/In       | dustry   |
| 121                 | within<br>ene.<br>than *  | m              | Elementary/Secondary (0-12)  | College (1-4or                                   | 5+)                            |                                | DO NOT use r   |                |                             |           |  | T . 1         | _                 | •  |
| d<br>2              | Hyg<br>the<br>int,  | e Co           | 12<br>17. Father's Name (First, Middle, L.   | n/a<br>ast)                                      |                                | Li                             | and Sur  |                |                             | s Name    | (First, Middle, N                        | Land          |                   | yıng   |
| an                  | 9 to 20 to  | To B           | George   | Gerho]   | ld                             |                                |  |                | Soph                        | nie       | ,  | Zimme         | rman              |  |
| Maryland 21215-0036 | S DE E  | -              | 19a. Informant's Name/Relationshi  |  |                                | 19b. Mailir                    | ng Address (Si                                       | treet a        |                             |           | l Route Number,                          |               |                   | Code)  |
|                     | and 2<br>lealth a<br>m 27 is<br>her trai  |                | Carol Spence/Da  | ughter   |                                | 6909                           | Oakrid   | lge            | Avenu                       | ıe,       | Chevy Cl                                 | nase,         | MD 20             | 0815   |
| ore                 | m O 1   |                | 20a. Method of Disposition  1     Burial 2 □ Cremation 3   | 3 Demoval from State                             |                                | ace of Dispo                   | sition (Name of                                      | of<br>r place  | ) 1                         | /2/       | ate 2                                    | 20c. Location | - City or To      | own, State                                     |
| Ě                   | Pages<br>ment of<br>ant: If it<br>ury or o  |                | `4 □Donation 5 □Other (Spe   |  |                                | ney V                          | alley M  | lem.           |                             |           |  | imoni         | um, Ma            | aryland  |
| Baltimore,          | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  |                | 21. Sign three Fureral rvice Li  | Ullas  | 4                              | D                              | Name and A<br>Name and A<br>Name and A<br>Name and A | une            | eral H                      | lome      | of Dula<br>Timoni                        | ney V         | alley<br>210      | Inc.   |
| п                   |   |                | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List of  | omplications that cause<br>nly one cause on each | d he death.<br>line.           |                                |  |                |                             |           |  |               | *****             | Approximate<br>Interval Between                |
|                     | Physician   |                | Immediate Cause (Fina disease of condition   | Cereb  | rovas                          | cular                          | Accide   | nt             |                             |           |  |               |                   | Onset and Death                                |
|                     | /Medical<br>Examiner  |                | resulting in death)  | Due to (or as                                    |                                |                                |  |                |                             |           |  |               |                   |  |
|                     | LAGIIIIICI  | _              | Sequentially list conditions,  | b  |                                |                                |  |                |                             |           |  |               |                   |  |
|                     | ted   | Examine        | if any, leading to immediate cause. Enter Underlying   | Due to (or as                                    | s a consequ                    | ence or):                      |  |                |                             |           |  |               |                   |  |
|                     | s be executed<br>sician and<br>burial-transit   | xar            | that initiated events<br>resulting in death) Last  | c. Due to (or as                                 | s a consequ                    | ence of):                      |  |                |                             |           |  |               |                   |  |
| 8760,               | ate be executed<br>hysician and<br>the burial-transit   | dical E        |  | d  |                                |                                |  |                |                             |           |  |               |                   |  |
| 9                   | ifficate I<br>g physi<br>as the b   | Ø.             |  |  |                                |                                |  |                |                             |           |  |               |                   |  |
| Вох                 | death certific<br>e attending pl<br>ed for use as t   | Physician/M    | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome<br>1 ☐ Live birth           |                                |                                | Ectopic pregn  | 3004           |                             |           |  | 23d. D        | ate of delive     | ery  |
|                     |   | sicie          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 4□Pregnant a<br>9□Unknown                        |                                |                                | Other (specif  |                |                             |           |  | N             | lonth             | Day Year                                       |
| P.0                 | by tack   | Phy            | 9 Unknown  | <u> </u>   |                                |                                |  |                |                             |           |  |               |                   |  |
| Ś                   | es<br>Ded   | by             | Part II. Other significant condition   |  |                                |                                | nderlying caus                                       | e givei        | n in Part I.                |           |  | _             |                   | ne cause of death?                             |
| orc                 | w requires<br>been sign<br>should be  | eted           | Dysphagia, Atı   | LIAI FIDEII                                      | Tat10                          | 0                              |  |                |                             |           | 1 76                                     | s ZUNO        | 3 [ FIOD          | ably 4 Munknown                                |
| 3ec                 | a sc  | ompleted       |  |  | -                              |                                |  |                |                             | _         | 24a. Was an<br>autopsy                   |               | prior to cor      | psy findings available<br>apletion of cause of |
| of Vital Record     | Th<br>ate<br>pag  | O              | OC Management of the state of t |  |                                |                                |  |                |                             |           |  | No            | death?            | 2□ No  |
| ž                   | sicia<br>cer<br>rect  | o Be           | 25. Was case referred to medical examiner?   | Hospital:  |                                | D/O                            |  | Other          |                             |           | Check on one                             |               |                   |  |
|                     | Phys<br>or this<br>oral di  | -              | 1 ☐ Yes 2 X No<br>27. Manner of Death  | 28a. Date of Inju                                | urv                            | R/Outpatien<br>28b. Time of    |  | Injury<br>Work | 4 M Nursi                   |           | ne 5 Resider                             |               |                   | ′)   |
| ion                 | Attending r death. ector: After by the fune   | atloi          | 1 XNatural 5 ☐ Pending 2 ☐ Accident investiga  |  | ay Year)                       | Injury                         |  |                | ?<br>es 2 ∐ No              |           |  |               |                   |  |
| Division            |   | tific          | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin  | ed 286. Place of In                              | jury - At hon<br>tc. (Specify) | ne, farm, str                  | eet, factory, of                                     | fice           |                             | 2         | 8f. Location (Str.<br>City or Town,      | eet and Num   | ber or Rura       | l Route Number,                                |
| Ö                   | spital or<br>ours afte<br>neral Dir<br>filled in  | Certification; |  | Jonaing, 6                                       | .s. (Spoony)                   |                                |  |                |                             |           |  | J1410)        |                   |  |
|                     | 한 수 할 수   | edical         | 29a. Certifier 1 Certifying (Check only 2 Medical Ex   | Physicien: To the best                           | of examination                 | vledge, death<br>on and/or inv | occurred at the                                      | ne time        | , date and p<br>nion, death | place, a  | nd due to the called at the time, da     | use(s) and m  | anner as st       | ated.<br>the cause(s)                          |
|                     | To the Hos<br>within 24 h<br>To the Fur<br>completely   | Med            | 29b. Signature and title of cedifier   | and manner si                                    | tated.                         |                                |  |                | number                      |           |  |               |                   |  |
|                     | N W W   | _              | Social distribution of the procedure of  | LLI  |                                |                                |  |                |                             |           | 29                                       | d. Date sign  |                   | Jay, (ear)                                     |
| 7                   | 181   |                | 30. Name and address of person w   | ho completed cause =4                            | death /lies                    | 232) /Tv-2                     |  | Z11            | .035                        |           |  | 12/29         | 7/05              |  |
|                     | 16×1  |                | Eugenio S. Mac   |  |                                |                                | ,  | Ro             | ad. S                       | 11v4      | er Morin                                 | g, MD         | 2090              | 14   |
|                     | Sta   | te             | 31. Date filed (Month, Day, Year)  |  |                                |                                |  | 1.0            | , 0                         | -T 4 (    | MATEL                                    | 6, III        | 2070              | •  |
| Pr <sub>li2</sub>   | Registr   |                | JAN 0 3  | 2006   | The A                          | Ire Jos                        |  |                |                             |           |  |               |                   |  |

| /Medic   | an  | 1. Decedent's Name (First, Middle, L.  | eybor   | Lucie  | Gueyda  | ın                                       |  | 2. Pat                                   | of Death<br>oth C<br>CC M   | le 30°   | ar 3. Time of De   |
|--|---|--|---|--|---|--|--|--|---|--|--|
| Examin   | er  | 4a. Facility Name (It not institution, gi Arden Court Assi: 5. Social Security Number 6.   | sted Livin  |  |   |  | r Location of D  | e<br>Hrs. 8 Date                         | of Birth  | Balti  |  |
| Funeral<br>Director  |   | 114-12-7201 Usual Residence of Decedent  | 1□M 2【X F   | 101  | Yrs. Mor  | nths Days                                | Hours  | Min. May                                 | 17, 19  | (r)  | lary land  |
| or 28a-f show  | ctor  | 10a. State 10b. County  Maryland Baltime   | ore   |  | Town or Location  | 1  |  |  |   |  | 10d. Inside City L   |
| or 28  | Director  | 10e. Street and Number   |   |  |   | f. Zip Code                              |  |  | 10g. (  | Citizen of What  | t Country?   |
| 23a  | la  | 8909 Reistersto  |   |  |   | 2120                                     |  |  |   | U.S.A  | ·  |
| penint. Tages I and 2 should be seen whill it index are bean will the way and Depertment of Health and Mental Hydiene. Important: if I lean 27 is marked other than "natural", or Itama 23a or 28a-f show any injury or other traumatic event, I're Medical Examiner must be multiled at once. | by Funeral  | 11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 12. Was Deceden Armed Forces 1  Yes 2 K If Yes, Give Year or Dates  | ?<br>] No  | If Yes  | Decedent of H<br>specify Cuba<br>es 2 No | lispanic Origin<br>an, Mexican, P<br>Specify:  | ? (Specify Ye<br>uerto Rican, e          | s or No-<br>tc.)  |  | Merican Indian,<br>White, etc.   |
| ne.<br>han "natu   | Completed   | 15. Decedent's E<br>(Specify only highest gi<br>Elementary/Secondary (0-12)  | College (1-4o   |  |   | of work done<br>OT use retired           | eation<br>during most of<br>d)   | working                                  | 16b.  | Kind of Busine   |  |
| Hygie<br>ther t  | S   | 17. Father's Name (First, Middle, Las  | 5+  |  | Att   | corney                                   | 18 Mother's  | Name (First,                             | Middle Maid   | Law  |  |
| d Mental h   | To Be   | Joseph J.  19a. Informant's Name/Relationship  | Gueyda  |  | 19b. Mailing Ad   | drass (Straat                            | Eli  | se                                       | Vincer  | nt   | ta Zin Codal   |
| trau   |   | Patrick Gueyda   |   |  | 4462 Cc   |  |  |  |   |  | and_ 21236   |
| ent of Hea<br>nt: If Item  |   | 20a. Method of Disposition  1  | ☐Removal from Stat  | 20b. Plac  | of Disposition  | (Name of                                 | ce)  | Date 2-2006                              | 20c.  |  | or Town, State   |
| Depertm<br>Importar<br>any Inju  |   | 21. Signature on Funeral Service Lice  | **  |  | 22. Nan   |  | ss of Facility   | Ruck                                     |   | Funera   | 1 Home, In<br>21204  |
| hysician<br>/Medical<br>xaminer  | er  | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,   | b   | L brown as a consequen   |   | -40                                      | mbo  | 13 6                                     |   |  |  |
| ohysician and<br>the burial-transit  | dical Examiner                                      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c   | s a consequer  |   |  |  |  |   |  |  |
| U 1  | dical   | that initiated events  | c   | is a consequer   | nce of):  | oic pregnancy                            | ,  |  |   | 23d. Date of<br>Month  |  |
| igned by the attending p<br>be detached for use as   | by Physician/Medical                                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No   | c   | is a consequer  of pregnance 2 Fetal deat time of deat                     | nce of):  y eath 3□Ector th 5□ Other  | or (specify)                             |  | 236                                      | o. Did tobacco  | Month o use contribute   | Day Yea  |
| igned by the attending p<br>be detached for use as   | by Physician/Medical                                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  | c   | is a consequer  of pregnance 2 Fetal deat time of deat                     | nce of):  y eath 3□Ector th 5□ Other  | or (specify)                             |  | 248                                      |   | Month  o use contribute  2 No 3   24b. Were prior death  | Day Yea  e to the cause of deat   Probably 4  Unk  e autopsy findings ava to completion of caus  |
| igned by the attending p<br>be detached for use as   | Be Completed by Physician/Medical                   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  | c   | is a consequer  of pregnance 2 Fetal deat time of deat                     | nce of):  y eath 3□Ector th 5□ Other  | ing cause giv                            | en in Part I.  | 248                                      | 1 Yes  . Was an autopsy performed? Yes 2 N  | Month  o use contribute  2 No 3   24b. Were prior death  | Day Yea  e to the cause of deat Probably 4 Unk  autopsy findings ava to completion of caus 17  |
| igned by the attending p<br>be detached for use as   | To Be Completed by Physician/Medical                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No 27. Manner of Death 1  Matural 5 Pending | c   | is a consequer  of pregnance 2 Fetal de  at time of deat  but not resultif | nce of):  y eath 3 □ Ectop th 5 □ Othe  ng in the underly  NOutpatient 3 □ Bb. Time of Injury | ing cause giv                            | 26. Place of er: 4 \( \text{Nursin} \) \( \text{var} \)  | 24a<br>1 Death (Checking Home 5          | 1 Yes  . Was an autopsy performed? Yes 2 N  | Month  o use contribute 2 No 3   24b. Were death 1 1  6- Other (5  | Day Yea  e to the cause of deat Probably 4 Unkn a autopsy findings ava to completion of caus Yes 2 No  |
| After this certificate has been signed by the attending F<br>funeral director, page 2 should be detached for use as  | To Be Completed by Physician/Medical                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1  Yes 2 No 27. Manger of Death                      | C. Due to (or a  d  | tient 2 EF   | y eath 3 □ Ector th 5 □ Other of the Underly  | DOA Cth                                  | en in Part I.  26. Place of er: 4 □ Nursin   | 246 10 Death (Check ng Home 5 [ 28d. De: | Was an autopsy performed? Yes 2 nonly one) Residence  | Month  o use contribute 2 No 3   24b. Were prior death 1    6 Other (S   | Day Yea  e to the cause of deat Probably 4 Unk autopsy findings ava to completion of caus y es 2 No  |
| After this certificate has been signed by the attending F<br>funeral director, page 2 should be detached for use as  | Certification; To Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | C. Due to (or a  d  | tient 2 EF jury ay Year)  at of my knowled of examination                  | eade, death occur   | DOA Oth  28c. Injur Wor 1                | 26. Place of er: 4 \( \triangle \tri | Death (Checking Home 5 [ 28d. Dec City   | Was an autopsy performed? Yes 2 nonly one) Residence ciribe how injustion (Street a or Town, Station the cause)             | Month  Duse contribute  2 No 3   24b. Were prior death of the prior de | Day Yea  The to the cause of deat  Probably 4 Unking avaitor completion of caus  Probably 19  Probably 4 No  Pr |
| his certificate has been signed by the attending p<br>I director, page 2 should be detached for use as   | To Be Completed by Physician/Medical                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | C. Due to (or a d. 23c. If yes, outcom 1   Live birth 4   Pregnant 9   Unknown contributing to death   1   Inpat   28a. Date of in (Month, Death of the building, etc.) | tient 2 EF jury ay Year)  at of my knowled of examination                  | eade, death occur   | DOA Oth  28c. Injur Wor 1                | en in Part I.  26. Place of er: 4 ☐ Nursir y at k? Yes 2 ☐ No  | Death (Checking Home 5 [ 28d. Dec City   | . Was an autopsy performed? Yes 2 nonly one) Residence scribe how injustion (Street a or Town, State at time, date a 29d. D | Month  Duse contribute  2 No 3   24b. Were prior death 1   6 Other (Sury occurred and Number or te)  s) and manner and place, and contribute and contribute and contribute and contribute and place, and contribute and place and contribute and contr | Day Yea  The to the cause of deat  Probably 4 Unking avaitor completion of caus  Probably 19  Probably 4 No  Pr |

|             |  |                   | 1 - For<br>State<br>Registrar  |   | aryland / De  |  | Health and I                   | Mental Hygie   | ne 0 0 5                                       | 42495                                       |
|-------------|--|-------------------|--|---|---|--|--------------------------------|--|--|---|
|             | Physic<br>/Medi<br>Examii  | cal               | Decedent's Name (First, Middle A   | E H   | ILL   | 4b. City, Town, o  | or Location of Death           | December   | Day Year 30 WD 5                               | 3. Time of Death                            |
|             | Funeral<br>Director  |                   | 5. Social Security Number  417-32-4386  Usual Residence of Decedent  | - 1   | +0SPITA<br>(In yrs. last birthda<br>79 Yrs.                           | J JA (19) If Under 1 Year Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth<br>(Month, Day, Ye<br>MARCH 14              | 9. Birth<br>Cou<br>1924 AL                     | Place (State or Foreign<br>ntry)<br>ABAMA   |
|             | within 72 hours after death with the Maryland<br>ane.<br>than "natural", or Items 23a or 28a-1 show<br>he Madical Exemple main be neilled at   | al Director       | 10a. State 10b. County  MARYLAND  10e. Street and Number   | U/A<br>LINS ST.   | 10c. City, Town or # APT 124  | Location  SAL  10f. Zip Code   | TIMOR<br>2126                  | RE C1  | Citizen of What Cou                            | 10d. Inside City Limits 1                   |
| 5-0036      | hours after dea<br>ural', or Items   | d by Funeral      | 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:  | 10  | 3. Was Decedent of H<br>If Yes, specify Cubin<br>1 ☐ Yes 2 🗷 No  | an, Mexican, Puert             | o Rican, etc.)   | 14. Race - Americ<br>Black, White,<br>Specify: | AACK  |
| 2121        | filed within 72 :<br>Hygiene.<br>other than "nat   | Be Completed by   | (Specify only highe Elementary/Secondary (0-12)  The CRADE  17. Father's Name (First, Middle,  |   | III   | cedent's Usual Occup<br>ve kind of work done<br>DO NOT use retired   | 10 WOI                         | king 16b   | SELF-E   |   |
| Maryland    | nit. Pages 1 and 2 should be filed within ortainent of Health and Mental Hygiene. ortaint: if Item 27 is marked other than injury or other traumatic event, the Met.   | ToB               | SAM  19a. Informant's Name/Relations  GLORIA BRAN  | hip (Type, Print)   | PERKI.  19b. Ma   | The state of the s | and Number or Ru               | ral Route Number, Cit  | WAL ty or Town, State, Zip                     | KER<br>Code)<br>2/223                       |
| Baltimore,  | permit. Pages 1 and<br>Department of Health<br>Important: If Item 27<br>eny injury or other to<br>ance.  |                   | 20a. Method of Disposition  12 Burial 2 Cremation  4 Donation 5 Other (S  21. Signature of Funeral Service   | pecify)   | MT, Z   | position (Name of rematory or other place)  ON CEME  22. Name and Addre  | TERY 1-0                       | 5-064  | Location - City or To                          | own, State                                  |
|             | Departition of the control of the co |                   | 23a. Part 1. Enter the disease, or<br>shook, or heart failure. List<br>Immediate Cause (Final  | complications that caused only one cause on each lin                  | the death. Do not e.e.  |  | FULTON<br>ng, such as cardiac  | AVE, BA<br>or respirator, arrest,                            |  |   |
| 760, <      | /Medical Examiner  sician and purial-transit   | dical Examiner    | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as:   | a consequence of):  A B E a consequence of):  STAG a consequence of): | TES  | ENAL                           |  | S<br>4-SE<br>)/SEASE                           |   |
| P.O. Box 68 | The law requires that the death certificate bate has been signed by the attending physic page 2 should be delached for use as the b  | Physiclan/Med     | fF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 mooks?<br>1 □ Yes 2 ☑ No<br>9 □ Unknown   | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown       | 2 Fetal death 3   | B ☐ Ectopic pregnancy  | ,                              |  | 23d. Date of delive<br>Month                   | ery<br>Day Year                             |
| Records, P  | w requires that the death cen<br>been signed by the attendin<br>should be detached for use   | þ                 | Part II. Other significant condition   | ons contributing to death bu  | it not resulting in the   | underlying cause giv   | en in Part f.                  | 1 ☐ Yes  |  | ably 4 Honknown                             |
| Vital Re    | ysician: The lav<br>is certificate has<br>director, page 2.  | Be Completed      | 25. Was case referred to medica examiner?  |   |   |  |                                | 24a. Was an autopsy performed 1 Yes 2 12 th (Check only one) | prior to cor<br>death?                         | psy findings available mpletion of cause of |
| of          | Jing Phy<br>I.<br>After this<br>funeral d  | Certification; To | 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendir 2 Accident investir 3 Suicide 6 Could   | 28a. Date of Injur<br>(Month, Day                                     | Year) Injury  | of 28c Injun<br>World  | y at                           | ome 5 Residence<br>28d. Describe how in                      | ijury occurred                                 |   |
| Divi        | or in b  |                   | 4 ☐ Homicide determ  29a. Certifier 1 ☐ Certifyir  | building, etc  g Physician: To the best of  Exeminer: On the basis of | f my knowledge, de  | ath occurred at the tig  | ne, date and place,            | and due to the cause   | (s) and manner as at                           |   |
|             | To the Hospital within 24 hours a To the Funeral I completely filled   | Medical           | 29b. Signature and title of certifie   | and mainer sta  | Z-m-1   | 29c. License   | e number                       | 29d. [   | Date signed (Month, I                          | Day, Year)                                  |
|             | H Sta  | te                | 30. Name and address of person  SITA  31. Date filed (Month, Day, Year)  | R. CRH  | Z M •   | Print)   | BON S                          | ECOUR  | s Hos  | 30,2005<br>PITAL                            |
| 1           | Registi  |                   |  | 3 2006  | w St.   | forth.   |                                |  |  |   |

|            |   |                | 1 - For State Registrar  | State of Mary  |                               |  | of He                | alth and                   | Mental Hy                                    |                              | 05                                   | 42496  |
|------------|---|----------------|--|--|-------------------------------|--|----------------------|----------------------------|--|------------------------------|--------------------------------------|--|
|            | Physic  |                | 1. Decedent's Name (First, Middle, Las   | 11:11  |                               |  |                      |                            | 2. Date of D                                 | Day                          | Year                                 | 3. Time of Death                               |
| 3          | /Medi<br>Exami  |                | 4a. Facility Name (If not institution, give  | street and number)                                       |                               | 4b. City. 1                                | own, or Lo           | ocation of De              | ath  |                              | b 05<br>ity of Death                 | 6:35 PM  |
|            | Exam  |                | 1-   | General Ho,  | wfu /                         | Co   |                      | 614                        |  |                              | were                                 | e  |
|            | Funeral   |                | 5. Social Security Number 6. Security Number 1                                     | ex 7. Age (Iff   | yrs. last birthday)           |  |                      | f Under 24 Hi<br>Hours Mir | n. (Month. D                                 | rth<br>ay, Year)             | 9. Birthp                            | place (State or Foreign                        |
|            | Director  |                | 238-30-8941 Usual Residence of Decedent  |  | 81 Yrs.                       |  |                      |                            | Jan. 1                                       | 7,1924                       | Nort                                 | h"Carolina                                     |
|            | 72 hours after death with the Maryland<br>nature!', or Items 23a or 28a-1 show<br>dicel Evarrinet must be notified at   | _              | 10a. State 10b. County MD Howard   | 100  | City, Town or Lo              |  |                      |                            |  |                              | 1                                    | 10d. Inside City Limits                        |
|            | s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene, item 27 Is marked other than "naturel", or Items 23a or 28a-1 shoot other traumatic event, the Medical Examiner must be notified at | Director       | MD Howard  |  | Ellicot                       |  |                      |                            |  |                              |                                      | 1 ☐ Yes 2√∑No                                  |
|            | with a  | D              |  | 70.4   |                               | 10f. Zip (                                 |                      |                            |  | 10g. Citizen o               |                                      | ntry?  |
|            | death   | Funeral        | 8109 Forest Hill 11. Marital Status  | 12. Was Decedent Ever                                    | in U.S. 13.                   |  | 1043                 | anic Origin? (             | Specify Yes or No                            |                              | SA<br>ace - Americ                   | can Indian                                     |
| 9          | after<br>or Ita   | E              | 1 ☐ Never Married 2 🔀 Married  | Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give                 | - 1                           | lf Yes, specr<br>1 □ Yes 2                 |                      |                            | nto Rican, etc.)                             |                              | ack, White,                          | etc.   |
| 21215-0036 | 2 should be filed within 72 hours after dea<br>and Mental Hygiene.<br>Is marked other than "natural", or Itams<br>eumatic event, the Medical Examiner ma  | d by           | 3 Widowed 4 Divorced   | Year or Dates: W   | WII                           |  |                      | Specify:                   |  | Spec                         | ity: Wh:                             |  |
| 15         | n "na"  | Completed      | 15. Decedent's Ed<br>(Specify only highest grad                                    | de completed)  | (Give                         | dent's Usual<br>kind of work<br>DO NOT use | done duri            | ing most of w              | orking                                       | 16b. Kind of I               | 3usiness/Ind                         | dustry   |
| 212        | giene<br>giene<br>er tha  | mo:            | Elementary/Secondary (0-12)  | College (1-4or 5+)<br>4                                  |                               |  | ,                    | strato                     | r  | Air &                        | Space                                | Contracts                                      |
| pu         | be file<br>tal Hy<br>d oth  | Be             | 17. Father's Name (First, Middle, Last)  |  |                               |  | 18                   | . Mother's Na              | ame (First, Middle                           |                              |                                      |  |
| Maryland   | Men Men narke   | 2              | Andrew Eugene H  |  |                               |  |                      |                            | n Lawrenc                                    |                              |                                      |  |
| Ma         | id 2 sl<br>th and<br>27 Is r<br>treur   |                | 19a. Informant's Name/Relationship (T<br>Doris Knorr Hill                          |  |                               |  |                      |                            | Rural Route Numb                             |                              |                                      |  |
| ē,         | permit. Pages 1 and 3<br>Department of Health<br>Important: If item 27<br>eny injury or other tn<br>once.   |                | 20a. Method of Disposition   | 20   | Db. Place of Dispo            |  |                      | LT DIT                     | ve; Ellic                                    | 20c. Location                |                                      |  |
| E O        | Pages<br>nent of<br>int: If it  |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐<br>`4 ☐ Donation 5 ☐ Other (Specify)                  |  | cemetery, cren<br>Metro Cre   |  |                      | 1-4                        | 4-2006                                       |                              |                                      | Maryland                                       |
| Baltimore  | permit. Pag<br>Department<br>Important:<br>eny injury o   |                | 21. Signature of Funeral Service Licens  |  | 22                            | . Name and                                 | Address of           | f Facility                 |  |                              |                                      |  |
| <u> </u>   | 8258  |                | Ceryon   | Palle  | 16                            | itzke<br>30 Ed                             | Funer<br>monds       | cal Hon<br>son Ave         | ne of Cat                                    | onsvill<br>onsvil            | le, In<br>Le, MI                     | 1c.<br>21228                                   |
|            |   |                | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of       | lications that caused the one cause on each line.        | death. Do not ent             | er the mode                                | of dying, s          | uch as cardia              | c or respiratory a                           | rrest,                       |                                      | Approximate<br>Interval Between                |
|            | Prrysician<br>/Medical  |                | Immediate Cause (Final disease or condition resulting in death)                    | a. Mult  | pe                            | Mye  | lan                  | 9                          |  |                              | /                                    | Onset and Death                                |
|            | Examiner  |                |  | Due to (or as a con                                      | mequence of):                 | 0  |                      |                            |  |                              |                                      |  |
|            |   | Je.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a con                                   | sequence of):                 |  |                      |                            |  |                              | -                                    |  |
| K          | ecuted<br>ind<br>transi   | Examiner       | that initiated events  | c  |                               |  |                      |                            |  |                              |                                      |  |
| 8760,      | sician and<br>burial-transit  | E Ex           | resulting in death) Last   | Due to (or as a con                                      | sequence of):                 |  |                      |                            |  |                              |                                      |  |
| 687        | the the   | edical         |  | d  |                               |  |                      |                            |  |                              |                                      |  |
| Вох        | eath certific<br>attending p<br>for use as  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome of pre                              |                               |  |                      |                            |  | 23d Da                       | ite of deliver                       | ny.  |
|            | deatle<br>ne atte   | sicia          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1 Live birth 2 ☐F<br>4 ☐ Pregnant at time<br>9 ☐ Unknown |                               | Ectopic pred<br>Other (spec                |                      |                            |  |                              |                                      | Day Year                                       |
| P.0        | that the de<br>ed by the detached   | Phy            | 9 Unknown  |  |                               |  |                      |                            |  |                              |                                      |  |
| ds,        | The law requires that the te has been signed by the hage 2 should be detache  | by             | Part II. Other significant conditions co   |  |                               |  |                      |                            | 11   | _                            | _                                    | e cause of death?                              |
| Ö          | w requ  | etec           | all o 5 1  | rcephalopse.   |                               | ypen                                       | men                  | 14                         |  |                              | 3 ☐ Proba                            | abiy 4 Unknown                                 |
| Record     | The lav   | Completed      | Itemal Pailure,  | Type I w   | obefer                        |  | le (l, f.            | ٠                          | 24a. Was<br>autop                            | sy                           | Were autop<br>prior to com<br>death? | esy findings available<br>apletion of cause of |
|            |   | a              | 25. Was case referred to medical   |  |                               |  | 0.0                  | Dines of De                | 1 ☐ Yes                                      | 2 □ NO                       |                                      | 2 No   |
| Ţ.         | s si b  | To B           | axaminer?  | Hospital: 1 Inpatient 2                                  | 2 ☐ ER/Outpatient             | 3□ DOA                                     | Other                |                            | ath <i>(Check only o</i> d<br>Home 5 ☐ Resid |                              | er /Snacify                          |  |
|            | ding Ph<br>h.<br>After th<br>funeral  |                | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year                  | 28b. Time of Injury           | 280  | . Injury at<br>Work? |                            | 28d. Describe h                              |                              |                                      | /  |
| sio        | en<br>eat<br>eat<br>or:<br>he   | icat           | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                            |  |                               | М  | 1 🗆 Yes              | 2 🗆 No                     | 1  |                              |                                      |  |
| 5          | o after in in   | Certification: | 4 Homicide determined  | 28e. Place of Injury - A<br>building, etc. (Spe          | it home, farm, stre<br>ecify) | et, factory, c                             | ffice                |                            | 28f. Location (S<br>City or Tow              | itreet and Numb<br>n, State) | er or Rural                          | Route Number,                                  |
| _          | urs<br>urs<br>eral  | <u>—</u>       | 29a. Certifier 1 Certifying Phys   | sician: To the best of my                                | knowledge, death              | occurred at                                | the time d           | ate and place              | and due to the                               | 221100(a) and ma             |                                      |  |
|            | To the Hosp<br>within 24 ho<br>To the Fund<br>completely f  | edica          | (Check only 2 Medical Examination)   | ner: On the basis of exam<br>and manner stated.          | ination and/or inv            | estigation, in                             | my opinio            | n, death occu              | rred at the time, o                          | date and place,              | and due to                           | ited.<br>the cause(s)                          |
|            | To the h<br>within 24<br>To the F<br>complete   | Σ              | 29b. Signature and title of certifier  |  |                               |  | icense nui           |                            |  | 29d. Date signe              |                                      |  |
|            | 5/1   |                | mil  | ~  | 170                           | D  | 746,                 | 120                        |  | Sec 3                        | 2 C                                  | 005  |
|            | 271   |                | 30. Name and address of person who co  | empleted cause of death (I                               | Item 23a) (Type, F            | rint)                                      |                      | ~                          | g, Colu                                      |                              | -                                    | -  |
|            | Sta   | to.            | 31. Date filed (Month, Day, Year)  | 10 72 4<br>32. Registrar's \$                            | nature -                      | Paters                                     | enf                  | Play                       | g, Colu                                      | m5,4                         | 170                                  | 21044  |
|            | Registr   | re             | JAN 0 3 2006   | place so   | Marie                         |  |                      | 0                          |  |                              |                                      |  |

|                     |   |                  | 1 For State   | State of  | Marylan            |                                  | artment of I                             |                              |                           |  |                                      | 1 5                     | 1 21 0 7                                  |
|---------------------|---|------------------|---|---|--------------------|----------------------------------|--|------------------------------|---------------------------|--|--------------------------------------|-------------------------|---|
| Í A                 | and the second  | ×                | Registrar  1. Decedent's Name (First, Middle,   | Last)   |                    | Cei                              | rtificate of                             | Death                        |                           | 2. Date of Dea                             | Reg. No. 0 (                         | 10                      | 3. Time of Death                          |
|                     | Physici<br>/Medic   |                  | Margaret  | Helm  | Hanz               | zlik                             |  |                              |                           |  | er <sup>Da</sup> 30 20               | ) 📆                     | 11:25 p                                   |
| 7                   | Examir  |                  | 4a. Facility Name (If not institution,  | -   | •                  |                                  | 4b. City, Town, o                        | or Location o                | of Death                  |  | 4c. County                           | of Death                | <del>-1</del>                             |
|                     | 1000  | . 9              | Stella Maris Ho   |   |                    |                                  | Timoniu                                  |                              | 0411-                     |  |                                      |                         | re County                                 |
| 19                  | Funeral Director  |                  | 5. Social Security Number 215 05 5835   | 6. Sex 7.<br>1 ☐ M 2 ☐ F                                    | Age (In yrs.       | last birthday)<br>Yrs.           | Months Days                              |                              | Min.                      | 8. Date of Birtl<br>(Month, Day<br>1ug. 28 | h<br>y, Year)<br>1907                | 9. Birth                | place (State or Foreign<br>ntry)<br>Vland |
|                     |   |                  | Usual Residence of Decedent   | 71  |                    |                                  |  |                              |                           | ug. Zo                                     | ,1507                                |                         |   |
|                     | within 72 hours after death with the Maryland<br>ene.<br>Then "naturel", or iteme 23a or 28a-f ehow<br>Ite Medical Examirer must be notified at | 5                | 10a. State 10b. County  |   | 10c. Cit           | y, Town or Lo                    |  |                              |                           |  |                                      |                         | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No    |
|                     | 28a-1   | Funeral Director | Maryland Baltim 10e. Street and Number  | ore   |                    | Essex                            | 10f. Zip Code                            |                              |                           |  | 10g. Citizen of V                    | Vhat Cou                |   |
|                     | h with  | O                | 4 Banyan Wood C   | ourt Uni  | t 202              |                                  | 2122                                     | 21                           |                           |  |                                      | USA                     | , y .                                     |
|                     | eme 3   | ner              | 11. Marital Status  | 12. Was Decede  | ent Ever in U      | .S. 13. \                        | Was Decedent of I<br>f Yes, specify Cub  | Hispanic Orig                | gin? (Spec                | offy Yes or No-                            | 14. Raci                             | e - Ameri               | can Indian,                               |
| 9                   | s atte  | by Fu            | 1 Never Married 2 Marrie<br>3 Natural Married 2 Marrie  |   | XNo                |                                  | 1 ☐ Yes 2 ☑ No                           |                              | ,                         | ,,   | Specify                              |                         | vhite                                     |
| ş                   | 2 hour  | ted k            | 15. Decedent  | s Education   | #S:<br>            | 16a. Deced                       | dent's Usual Occup                       | pation                       |                           |  | 16b. Kind of Bu                      | isiness/lr              | ndustry                                   |
| 25                  | thin 7.   | Completed        | (Specify only highest<br>Elementary/Secondary (0-12)  | Grade completed)  College (1-4)                             | or 5+)             | (Give                            | kind of work done<br>DO NOT use retire   | during most<br>d)            | of working                | 9  |                                      |                         | ,   |
| 2                   | illed wi<br>Hygien<br>other th  | Cou              | unknown   |   |                    | Ac                               | lministra                                | 1                            |                           | 15:  |                                      |                         | vernment                                  |
| Maryland 21215-0036 | d a b   | 9 Be             | 17. Father's Name (First, Middle, L<br>Joseph   | Helm  |                    |                                  |  |                              | rs Name (<br>Anna         |  | <i>Maiden Suma</i> m<br><b>uer</b>   | θ)                      |   |
| <u> </u>            | should<br>and Men<br>marke<br>umatic  | To               | 19a. Informant's Name/Relationsh  |   |                    | 19b. Mailin                      | ng Address (Street                       |                              |                           |  |                                      | State, Zij              | o Code)                                   |
|                     | is 1 and 2 shou<br>of Health and M<br>item 27 is mar<br>other traumat   |                  | Marian Donne  | (daugh  |                    |                                  |  |                              | t Uni                     | t 202 1                                    | Essex, N                             | (ary                    | land 21221                                |
| baltimore,          | ges 1<br>t of He<br>if iter<br>or oth   |                  | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation   | 3 □Removal from Str   |                    |                                  | sition (Name of<br>natory or other pla   |                              | Da                        |  | 20c. Location -                      | •                       |   |
|                     | permit. Pages<br>Department of H<br>important: If its<br>eny injury or of<br>once.  |                  | 4 Donation 5 Other (Sp<br>21. Signature of Europe States  | ecify)  | Ba]                |                                  | Cemeter  Name and Addre                  |                              |                           |  |                                      |                         |   |
| Ra                  | Depa<br>impo<br>eny i   | -                | 21. Signatur  |   | _                  |                                  | 107 Old E                                |                              |                           |  |                                      |                         |   |
| 9                   | 1   |                  | 23a. Part 1 Enter the disease, or o shock, or heart failure. List o   | complications that cau                                      | sed the deat       |                                  |  |                              |                           |  |                                      | Tark                    | Approximate<br>Interval Between           |
|                     | Physician   |                  | Immediate Cause (Final disease or condition   |   |                    | ERAT                             | ic CARI                                  | DIDUAS                       | culat                     | D/   | SENSE                                | -                       | Onset and Death                           |
|                     | /Medical<br>Examiner  |                  | resulting in death)   | Due to (or  | as a conseq        | uence of):                       |  |                              |                           |  |                                      |                         |   |
| 1                   |   | ē                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or   | as a conseq        | uence of):                       |  |                              |                           |  |                                      |                         |   |
| 9                   | cuted<br>nd<br>ransit   | Examiner         | that initiated events   | С.  |                    |                                  |  |                              |                           |  |                                      |                         |   |
| Š                   | be executed<br>icien and<br>burial-transit  | i Ex             | resulting in death) Last  | Due to (or  | as a conseq        | uence of):                       |  |                              |                           |  |                                      |                         |   |
| 28/60               | eath certificate be executed attending physicien and for use as the burial-transit  | dicai            |   | d   |                    |                                  |  |                              | -                         |  |                                      |                         |   |
| POX P               | death certificate e attending phys d for use as the   | n/Me             | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcom   |                    |                                  |  |                              |                           |  | 23d. Date                            | e of deliv              | arv.                                      |
| Ď.                  | death<br>e atte   | Physician/Me     | in the past 12 months?<br>1 ☐ Yes 2 🗷 No  | 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown                      | t at time of d     |                                  | Ectopic pregnancy Other (specify)        | У                            |                           |  | Mor                                  |                         | Day Year                                  |
| л<br>Э              | res that the de<br>signed by the a<br>be deteched t   | Phy              | 9 Unknown   |   |                    | MAIL - I - Ab                    |  |                              |                           | CO. Dilan                                  |                                      |                         |   |
| ഗ                   | requires to<br>een signe<br>nould be o  | d by             | Part II. Other significant condition  | a continuiting to deat                                      | H Dat Hot 195      | utting in the ur                 | idenying cause giv                       | ren in Parti.                |                           |  | _                                    |                         | he cause of death?                        |
| ecord               | > 0 70  | ete              |   |   |                    |                                  |  |                              |                           | 24a. Was a                                 |                                      |                         | ppsy findings available                   |
| r                   | 0 - 0   | Completed        |   |   |                    |                                  |  |                              |                           | autops<br>perform                          | med? d                               | rior to co              | mpletion of cause of                      |
| VItal               | lysician: Th  | Вес              | 25. Was case reterred to medical examiner?  |   |                    |                                  |  |                              | of Death (                | Check only on                              |                                      |                         | 2010                                      |
| ō                   | Phys<br>this<br>aldi  | 2                | 1 ☐ Yes 2 🛣 No<br>27. Manner of Death   | Hospital: 1 Inp   |                    | ER/Outpatien                     |  | 4   1401                     |                           |  |                                      |                         | WHOSPICE                                  |
| 0                   | ding<br>th.<br>: Atter<br>tunes   | tlon             | 1 Natural 5 Pending 2 Accident investiga  | (Month,   | Day Year)          | Injury                           | Wor                                      | yat<br>rk?<br>Yes 2 □ N      |                           | o. Describe no                             | ow injury occurre                    | ы                       |   |
| DIVISION            | er dea<br>rector<br>by the  | Certification:   | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin   | ed 28e. Place of  | Injury - At ho     | ome, farm, stre                  | eet, factory, office                     |                              | 28                        | If. Location (St<br>City or Town           | treet and Number                     | r or Rura               | al Route Number,                          |
| 5                   | rital or<br>rai Dir<br>lled in  |                  |   |   |                    |                                  |  |                              |                           |  |                                      | _                       |   |
|                     | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely tilled in by the funer                      | edical           | 29a. Certifier 1 Certifying (Check only 2 Medical E   | Physician: To the be<br>reminer: On the basis<br>and manner | s of examinat      | wledge, death<br>tion and/or inv | occurred at the tire estigation, in my o | me, date and<br>pinion, deat | d place, an<br>h occurred | nd due to the ca<br>d at the time, d       | ause(s) and mar<br>late and place, a | nner as st<br>nd due to | tated.<br>o the cause(s)                  |
|                     | ro the<br>vithin 2<br>ro the<br>comple  | Med              | 29b. Signature and little of certifier  | ) and manner  | Stated.            |                                  | 29c. Licens                              | e number                     |                           | 2  | 9d. Date signed                      | (Month,                 | Day, Year)                                |
| 7                   | ->-0  |                  |   | 6   |                    |                                  | 1)                                       | 1777                         | 1                         |  |                                      |                         |   |
|                     | X   |                  | 30. Name and address of person w  | ho completed cause of                                       | of death (Item     | 23a) (Type, I                    | Print)                                   | . ) / 2                      |                           |  | 41                                   |                         | 21093                                     |
|                     | 0.00  | <b>t</b> a       | DR TARIA MA   | HM00D<br>32. Regi   | 330 istrar's Sinna | O DUL                            | ANEX L                                   | ALLEY                        | RO                        | Tim  | onlum;                               | MD                      | 21093                                     |
|                     | Sta<br>Registr  |                  | 31. Date filed (Month, Day, Year)<br>JAN 0 3 200  | 6 Gerene  | H.                 | Goods                            | ANEX L                                   |                              |                           |  |                                      |                         |   |

| Please Type of | r Print ir | Black In | ndelible Ink. | Ensure All | Copies | Are Legible |
|----------------|------------|----------|---------------|------------|--------|-------------|
|                |            |          |               | 111 1 1 1  |        | ,           |

|            |   |                | For<br>State<br>Registrar                                     | State of                          | Marylan                         |                  | artment of F                            |   | Mental Hygi                              | ene                | 05             | 42498                                       |
|------------|---|----------------|---|-----------------------------------|---------------------------------|------------------|---|---|--|--------------------|----------------|---|
|            | P. 10   | ٠              | Decedent's Name (First, Middle, I                             | Last)                             |                                 |                  |   |   | 2. Date of Death<br>Month                |                    | Vana           | 3. Time of Death                            |
| 6          | Physici<br>/Medic   |                | Katherine Eli   | zabeth H                          | o1den                           |                  |   |   | December                                 | 3o                 | 2005           | 01:20 A.M.                                  |
| à          | Examin  |                | 4a. Facility Name (If not institution, g BATTIMORE Washington | or Mczical                        | Cent                            |                  |   | Burnic  If Under 24 Hrs.                  |  |                    | Peur           |   |
| 9.         | Funeral Director  |                | 5. Social Security Number 6. 231–20–2633                      | . Sex 7.<br>1 ☐ M 2 💢 F           | Age (In yrs. 84                 | Yrs.             | Months Days                             | Hours Min.                                | 8. Date of Birth (Month, Day, ) July 12, |                    | Goun           | lace (State or Foreign<br>try)<br>VA        |
|            |   |                | Usual Residence of Decedent                                   |                                   |                                 |                  |   |   | July 12                                  | 1721               |                |   |
|            | anylar<br>show  | _              | 10a. State 10b. County  |                                   | 10c. Cit                        | y, Town or Lo    |   |   |  |                    | 16             | 0d. Inside City Limits 1 ☐ Yes 2√ No        |
|            | 28a-1   | Director       | MD Anne   | Arundel                           |                                 |                  | Glen Bu                                 | rnie                                      | 100                                      | g. Citizen of      | What Coun      |   |
|            | 3a or   |                | 102 N. Crain H  | ww An                             | t. 940                          |                  | ,                                       | .061                                      |  |                    | USA            | •   |
|            | ama 2   | Funerai        | 11. Marital Status  | 12. Was Decede                    | ent Ever in U.                  | S. 13. V         |   | lispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No-<br>o Rican, etc.)      |                    | ce - Americ    |   |
| 9          | filed within 72 hours after deeth with the Maryland<br>Hygiene.<br>other than "natural", or Itama 23a or 28a-f show<br>ent, the Macinal Examinational be multified at | by Fu          | 1 ☐ Never Married 3 ☐ Widowed 4 ☐ Divorced                    | 1 ☐ Yes 25                        | <b>XX</b> 100                   | •                | ☐ Yes ※XNo                              | Specify:                                  |  | Speci              |                | African                                     |
| 9500-91212 | tural stural  |                | 15. Decedent's  | Year or Date                      | 35:                             |                  | ent's Usual Occup                       |   |  | Bb. Kind of B      |                | nerican<br>Justry                           |
| 212        | hin 72  | Completed      | (Specify only highest of Elementary/Secondary (0-12)          | grade completed) College (1-4     | or 5+)                          | (Give            | kind of work done<br>OO NOT use retired | during most of wor<br>d)                  | king                                     |                    |                |   |
| 7          | ygien<br>ygien<br>rer th  | Con            | 10  |                                   |                                 |                  | Nursing A                               | ssistant                                  |  |                    | Medi           | cal   |
| ם<br>פער   | P d la  | Be             | 17. Father's Name (First, Middle, La                          | _                                 |                                 |                  |   |   | ne (First, Middle, Ma                    |                    | me)            |   |
| Maryland   | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other traumatic   | 은              | Coleman Chandl  19a. Informant's Name/Relationship            |                                   | _                               | 19b. Mailin      | a Address (Street                       |   | rine Gree                                |                    | , State, Zip   | Code)                                       |
|            | and 2 sealth arm 27 is ner trau   |                | Mr. Dallis M. Ho  |                                   | sband                           | 1.00             | N. Crain                                |   | t. 940,                                  |                    |                | e, MD 21061                                 |
| saltimore, | ges 1 a<br>it of Hea<br>if item<br>or othe  |                | 20a. Method of Disposition  1 Burial 2XXCremation 3           |                                   | 20b. P                          | lace of Dispos   | sition (Name of natory or other place   | (9)                                       | Date 20                                  | c. Location        |                |   |
| Ĕ          | Pages<br>ment of<br>lant: If it   |                | 4 Donation 5 Other (Specialist)                               |                                   | 1                               | esapeal          | ke Cremat                               | ion Ja                                    | n 2,<br>006                              | Stever             | nsvill         | e, Maryland                                 |
| g<br>Q     | permit. Par<br>Depertment<br>Important:<br>any injury   |                | 21. Signature of Funeral Service Lic                          | ensee                             | /.                              |                  | . Name and Addre                        |   | _  |                    |                | Home, P.A.                                  |
| Æ          |   |                | 23a. Part1. Enter the disease, or co                          | mplications that cau              | sed the death                   |                  | 1 Secon                                 | id Ave SW                                 | Glen B<br>or respiratory arres           | urnie,             | Mary           | land 21061 Approximate                      |
|            | Physician   |                | shock, one art failure. List on<br>Immediate Cause (Final     | ly one cause on eac               | n line.                         |                  |   |   |  |                    |                | Interval Between<br>Onset and Death         |
| į .        | Physician<br>/Medical   |                | disease or condition resulting in death)                      | a. Due to (or                     | as a consequ                    |                  | Throm                                   | 692.7                                     |  |                    |                |   |
|            | Examiner  |                | Sequentially list conditions,                                 | b                                 |                                 |                  |   |   |  |                    |                |   |
| 2          | pe is   | iner           | cause. Enter Underlying Cause (Disease or injury              | Due to (or                        | as a richsaqu                   | sence of):       |   |   |  |                    |                |   |
|            | icate be executed<br>physicien and<br>s the burial-transit  | Examiner       | that initiated events<br>resulting in death) Last             | c.<br>Due to (or                  | as a consequ                    | uence of):       |   |   |  |                    | -              |   |
| 8/PU       | ysicier<br>e buri   | dicai          |   | d                                 |                                 |                  |   |   |  |                    |                |   |
| ٥          | ntifica<br>ing ph   | Medi           | IF FEMALE:  |                                   |                                 |                  |   |   |  |                    |                |   |
| gox        | death certificate<br>e ettending phys<br>ed for use as the  | Physician/Me   | 23b. Was decedent pregnant<br>in the past 12 months?          |                                   | n 2 ☐ Fetal                     | death 3          | Ectopic pregnancy                       |   |  |                    | ite of deliver | ry<br>Day Year                              |
| o,         | the de<br>y the e   | ysic           | 1 Yes 2 No  | 9☐ Unknow                         | t at time of de                 | eath 5           | Other (specify)                         |   |  |                    |                |   |
| S)         | w requires that the de<br>been signed by the c<br>should be detached  | by Pł          | Part II. Other significant conditions                         | contributing to deat              | h but not resu                  | ulting in the un | derlying cause giv                      | en in Part I.                             | 23e. Did toba                            | cco use con        | tribute to the | e cause of death?                           |
| cords      | law requires Ihaf<br>as been signed b<br>2 should be dete   |                |   |                                   |                                 |                  |   |   | 1 Tes                                    | 2 No               | 3 Proba        | ably 4 Unknown                              |
| a)         | law ranga ba  | Completed      |   |                                   |                                 |                  |   |   | 24a. Was an autopsy                      |                    | prior to corr  | sy findings available inpletion of cause of |
| r<br>ā     | sician: The law<br>certificate has b<br>irector, page 2 s   |                |   |                                   |                                 |                  |   |   |  | id?<br><b>≹</b> No | death?         | 2□ No                                       |
| VII        | Physician:<br>this certific   | o Be           | 25. Was case referred to medical examiner?  1 Yes 2 No        | Hospital: 1 Xnp                   | ationt 2                        | EB/Outpotion/    | Oth                                     | or.                                       | th (Check only one)                      |                    |                |   |
| 0          | Phy<br>this   | $\vdash$       | 27. Manner of Death   | 28a. Date of I                    |                                 | 28b. Time of     | 3 DOA                                   | y at                                      | ome 5 Residence 28d. Describe how        |                    |                | /   |
| 0          | tendin<br>Jeath.<br>tor: Aft<br>the fun   | atlo           | 1 Natural 5 Pending 2 Accident investigat                     | ion                               | Day (Gar)                       | Injury           |   | Yes 2 □No                                 |  |                    |                |   |
| DIVISION   | or Atte   | Certification: | 3 ☐ Suicide 6 ☐ Could not determine                           | 289. Place of                     | Injury - At ho<br>etc. (Specify | ome, farm, stre  | et, factory, office                     |   | 28f. Location (Stre<br>City or Town,     |                    | ber or Rural   | Route Number,                               |
|            | pital<br>ours a<br>eral C   |                | 29a. Certifier 1 Certifying I                                 | Physician: To the be              | est of my know                  | wiedne death     | occurred at the tim                     | ne, date and place                        | and due to the cau                       | co(c) and m        | 20005 20 010   | atad .                                      |
|            | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune   | edicai         | (Check only 2 Medical Ex-<br>one)                             | aminer: On the basi<br>and manner | s of examinat                   | tion and/or inv  | estigation, in my o                     | pinion, death occu                        | rred at the time, date                   | and place,         | and due to     | the cause(s)                                |
|            | To th<br>withir<br>To th<br>comp  | M              | 29b. Signature and title of certifier                         | (                                 |                                 |                  | 29c. Licens                             |   |  | l. Date signe      | d (Month, E    | Day, Year)                                  |
| 1          | j   |                | I tem tue   | rio Mo                            |                                 |                  | DO                                      | 27415                                     | $D_{\alpha}$                             | ecentr             | ~ 30,          | 2005  |
|            | H   |                | 30. Name and address of person wh                             | hington N                         |                                 |                  | - (4( (L)                               | ilen Bu                                   |  |                    |                |   |
| 18         | Sta   | te             | 31. Date filed (Month, Day, Year)                             |                                   | istrar's Signa                  |                  | יודי, כ                                 | IICN DO                                   | (1.11)                                   |                    |                |   |
|            | Registr   | -              | JAN 0 3 20  | 06                                | w He                            | 1004             |   |   |  |                    |                |   |

|                |   | 4                 | 1 - For<br>Stata<br>Registrar  | State of  | of Marylar   |   | artment of F<br>tificate of                             | lealth and I<br>Death                                 |                                       | giene<br>Reg. No.2 () (         | 05                           | 42499  |
|----------------|---|-------------------|--|---|--|---|---|---|---------------------------------------|---------------------------------|------------------------------|--|
| i              | Physicia  |                   | Decedent's Name (First, Middle, La  James  |   | enry   | L   | arris   |   | 2. Date of De<br>Month                | Day<br>ber 30,                  | Year<br>2005                 | 3. Time of Death 5:40PmM                     |
| 3              | /Medic<br>Examin  | _                 | 4a. Facility Name (If not institution, give  |   |  |   |   | r Location of Death                                   |                                       | 4c. County                      |                              | J. 401 III                                   |
|                |   | •                 | Bradford Oaks  |   |  |   | Clinto  |   |                                       | Prince                          | Geor                         | rge's  |
|                | Funeral<br>Director   |                   | 5. Social Security Number 443-34-9906 6. S   | ex<br>☑M 2□F  | 7. Age (In yrs. 72   | last birthday)<br>Yrs.                      | If Under 1 Year Months Days                             | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birt<br>(Month Da<br>April | , 1933                          | 9. Birthpl<br>Coun<br>OK I   | lace (State or Foreign<br>try)<br>anoma      |
|                | and w   |                   | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. Ci  | ty, Town or Lo                              | cation  |   |                                       |                                 | 11                           | 0d. Inside City Limits                       |
| 0036           | Manyli<br>feho  | ō                 | Florida Pinella  | ıs  | 9  | St. Pet                                     | ersburg   |   |                                       |                                 |                              | 1∑∏Yes 2 ☐ No                                |
|                | r 28e   | Directo           | 10e. Street and Number   |   |  | 700   | 10f. Zip Code   |   |                                       | 10g. Citizen of W               | /hat Coun                    | try?   |
|                | th with   | al D              | 2596 52nd Avenue   | e N   |  |   | 33714   |   |                                       | U.S.A.                          |                              |  |
|                | be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "naturel", or iteme 23a or 28e-f ehow event, the Medical Examiner must be motified at                 | ted by Funeral    | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Dec<br>Armed F<br>1 X Yes<br>If Yes, G<br>Year or I | 2 □ No<br>ve   | 1   | Was Decedent of H<br>f Yes, specify Cub<br>I ☐ Yes 2 No | lispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pecify Yes or No<br>o Rican, etc.)    | 14. Race<br>Black               | Americ<br>k, White, o<br>Wh: |  |
| 5              | 72 hou  |                   | 15. Decedent's E<br>(Specify only highest gr   |   |  | 16a. Deced                                  | lent's Usual Occup                                      | pation  | kina                                  | 16b. Kind of Bu                 | siness/Inc                   | lustry                                       |
| 9500-61212     | within 72<br>ene.<br>than "nat  | Completed         | Elementary/Secondary (0-12)  | College (   |  |   |   | during most of word)                                  | y                                     | C C                             |                              |  |
| פ              | filed w<br>Hygier<br>other th   | To Be Con         | 12th  17. Father's Name (First, Middle, Last   | 2   |  | 1 1   | Receiver  | 18 Mother's Nan                                       | ne /First Middle                      | Safeway Maiden Sumam            | _                            |  |
|                | d be f  |                   | Claude Harris  |   |  |   |   | Lela  | Will:                                 |                                 | 0,                           |  |
|                | 2 should be to and Mental is marked o raumatic eve  |                   | 19a. Informant's Name/Relationship   |   |  |   |   | and Number or Ru                                      |                                       |                                 |                              |  |
| Mar            | and 2<br>selth a<br>n 27 io   |                   | Nickoleen Harris   | (Wife)  | )  | 259   | 6 52nd A  | ve. North   | St. Pe                                | tersburg                        | , F1                         | orida 33714                                  |
| saltimore,     | of He   |                   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special  |   | 04   | Place of Dispo<br>cemetery, crer<br>e Crema | sition (Name of<br>natory or other pla<br>tory          | Jan 2006  |                                       | 20c. Location - Clinton,        | -                            |  |
| Ball           | permit. Page<br>Department<br>important: if<br>eny injury or<br>once.   |                   | 21. Signature / Funeral Service Lice   | mol <sup>c</sup>  | 161  |   |   | ss of Facility Lee<br>1exandria                       |                                       |                                 |                              | MD 20735                                     |
|                |   |                   | 23a. Print1. Enter the disease, or comprise the control of the con | plications that   | caused the dea   |   |   |   |                                       |                                 |                              | Approximate<br>Interval Between              |
|                | Physician   |                   | Irremediate Cause (Final   | <   | 1  | sko   |   |   |                                       |                                 |                              | Onset and Death                              |
|                | /Medical<br>Examiner  |                   | resulting in death)  Due to (or as a consequence   |   |  |   |   |   |                                       |                                 |                              |  |
|                | Lammer  | er                | Sequentially list conditions,  | b. Divers   | 10/25 2 000500   | Tuence of):                                 | oppe  | on  |                                       |                                 |                              |  |
| T              | ted   | nlne              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c   |   |  | isequence or).                              |   |   |                                       |                                 |                              |  |
| /<br>ゴ         | be executed<br>sicien and<br>burial-transit   | Examine           |  |   |  | quence of):                                 |   |   |                                       |                                 |                              | · · · · · · · · · · · · · · · · · · ·        |
| 09/8           | icate be executed<br>physicien and<br>s the burial-transi   | Physician/Medical | (  | d   |  |   |   |   |                                       |                                 |                              |  |
| 9              | entifica<br>ding pl   |                   | IF FEMALE:   | 22a Hwas a  | strome of progn  | 2001  |   |   |                                       |                                 |                              |  |
| O. Box         | The law requires that the death certificate hes been signed by the ettending page 2 should be detached for use as   |                   | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 Live  | itcome of pregn<br>birth 2 □ Feta<br>nant at time of a<br>nown | aldeath 3                                   | Ectopic pregnanc<br>Other (specify)                     | <b>y</b>  | 12                                    | 23d. Date<br>Mor                | e of delive<br>nth           | ry<br>Day Year                               |
| a.             | s that I  | by Ph             | Part II. Other significant conditions  | contributing to   | leath but not re   | sulting in the u                            | nderlying cause giv                                     | ven in Part I.  | 23e. Did to                           | obacco use contr                | ibute to th                  | e cause of death?                            |
| g              | w requires<br>been sign<br>should be  | ed b              | Vamante  | - /   | 06   | don   | reno  | /   | 101                                   | res 2□No                        | 3 🗌 Prob                     | ably 4 Unknown                               |
| Vital Records, | aw re<br>ss bee<br>2 sho  | Completed         | mortin a   | una   |  | zet.  | n. L  | one   | 24a. Was                              | an 24b. V                       | Vere autor                   | psy findings available inpletion of cause of |
| ř              | The ete he  | Com               | diserdo  | 2   | 0  |   |   |   |                                       | rmed?? d                        | leath?                       |  |
| /Ita           | cian:<br>ertific<br>ector,  | Be                | 25. Was case referred to medical examiner?   | Hospital:   |  |   |   |   | ith (Check only o                     |                                 |                              |  |
|                | Phyei<br>this o   | 2                 | 1 ☐ Yes 2 ☐ No<br>27. Manner of Death  | 28a. Date   |  | ER/Outpatier<br>28b. Time of                | t 3 DOA   | Nursing H   |                                       | dence 6 Other                   |                              | )  |
| 0              | ding<br>h.<br>After<br>tune   | tlon              | 1 Natural 5 Pending 2 Accident investigation   | (Moi  | nth, Day Year)   | Injury                                      | Wo  | rk?`<br>Yes 2 ⊡No                                     | 250.000.00                            | ow anjary coccan                | 00                           |  |
| Division of    | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificete hes completely filled in by the funeral director, page 2: | Certification:    | 3 Suicide 6 Could not to determined  | e 28e. Plac   | e of Injury - At I<br>ling, etc. (Speci                        | nome, farm, str<br>fy)                      | eet, factory, office                                    |   | 28f. Location (S<br>City or Tox       | Street and Number<br>vn. State) | er or Rura                   | Route Number,                                |
|                | To the Hospital or within 24 hours atte to the Funeral Dir completely filled in it  | Medical C         | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   |   |   |                                       |                                 |                              |  |
|                | ro the routhin routher somple   |                   | 29b. Signature and title of certifier  |   |  |   | 29c. Licens   | se number   |                                       | 29d. Date signed                | (Month, I                    | Day, Year)                                   |
|                |   |                   | Vene 1   | 2/5/2   |  | 2 /M  | 000   | 1225  | 79                                    | ben ;                           | 3, 2                         | 2006   |
|                | 5   |                   | 30. Name and address of person who Rene Grace M.D  |   |  |   |   | Clinton,  | Marylan                               | d 20735                         | <u>'</u>                     |  |
|                | Sta   | ite               | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   |   |  |   |   |   |                                       |                                 |                              |  |
| 2              | Regist  | ar                | JAN 0  | 3 2006  | Property.  | A.  | South   |   |                                       |                                 |                              |  |

DHMH 17 Rev 1/2001

ORIGINAL

Amend item#10e, perfff, 6851,1-3-06 f11

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Harrison Month Day Year **Physician** 3:30 An aVI ec 2005 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Bal timor Baltimore omwel 8. Date of Birth (Month, Day, May 7, ] Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number Months Hours Min. Deys 1 X M 2 □ F Yrs. 84 MD 214-12-8789 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐ Yes 2 X No Funeral Director Baltimore Cockeysville 10e. Street end Number 10333 1<del>033</del> Malcolm Cir. 10g. Citizen of What Country? 21030 USA Apt. A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 X Yes 2 □ No 1 ☐ Yes 2 X No Specify: White Specify. Completed by 3 Widowed 4 Divorced Year or Dates: 43-46 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) 12 2 Salesman Black & Decker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) æ Mathilda McGall Leslie Rockwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 28698 Murrelet Drive Laguna Nieguel, CA 92677 Richaed Harrison/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Jan. 6 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2006 Woodlawn, MD Licensee 21. Signature of Funeral Second 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part. Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as e consequence of): Due to (or as e consequence of):

Physician /Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed

**Funeral** 

Director

permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Merylend Depertment of Health end Mentel Hygiene. Important: If Item 27 ia marked other than "nature!" And the fraumatic events any injury or other traumatic events.

ed by the ettending physician and deteched for use as the buriel-trer

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical Certification: To Be Completed by Physician/Medical Examiner use es the buriel-trensit certificate hes 

Division of Vital Records, P.O. Box 68760

resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ₩No 26. Place of Death (Chec

1 ☐ Yes 2 ☐ No

| CK OHLY OHE) |                    |
|--------------|--------------------|
| Residence    | 6 ☐Other (Specify) |
|              |                    |

| 25. Was case referred to medical            |  |                     | 26. Place of Dea         | 26. Place of Death (Check only one) |  |  |  |
|---|--|---------------------|--------------------------|-------------------------------------|--|--|--|
| examiner?<br>1 ☐ Yes 2 ☐ No                 | Hospital: 1 ☐ Inpatient 2 ☐              | ER/Outpatient 3□ D  | OA Other: 4 Driversing H | lome 5 ☐ Residence 6 ☐ Other        |  |  |  |
| 27. Manner of Death 1 ☑ Naturel 5 ☐ Pending | 28a. Date of injury<br>(Month, Dey Year) | 28b. Time of Injury | 28c. Injury et<br>Work?  | 28d. Describe how injury occurre    |  |  |  |

| 1 Naturel 2 Accident        | 5 Pending investigation   | (MOHIII, Dey Year)                                     |
|-----------------------------|---------------------------|--|
| 3 ☐ Suicide<br>4 ☐ Homicide | 6 Could not be determined | 28e. Place of tnjury - At hor building, etc. (Specify) |

home, farm, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🕠 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

|  | 19jistin | (Jao, MD) |  |
|--|----------|-----------|--|
|--|----------|-----------|--|

29d. Date signed (Month, Dev. Year)

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

Blvd aven

31. Date filed (Month, Day, Year) State JAN 0 3 2006 Registrar

32. Registrer's Signature Bar Buch

merce

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